

**Estimates of childhood behavioural problems in Malaysia and their  
relationship with parenting behaviour**

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## **DECLARATION**

I declare that this thesis is my own work and that, to the best of my knowledge and belief, it does not contain material from published sources without proper acknowledgement, nor does it contain material which has been accepted for the award of any other higher degree or graduate diploma in any university.



Aida Farnana Hj Suhaimi

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## **Abstract**

This study examined estimates of different types of childhood behavioural problems based on reports from 1407 parents of primary school children aged 5 to 13 years from Klang Valley, Malaysia using the Strengths and Difficulties Questionnaire (SDQ). It also examined the mean and standard deviation scores for the scales in the SDQ, and how these scores are influenced by age and gender. Additionally, it examined the relationship of childhood behavioural problems with parental warmth and rejection. The results indicated that the percentages of children within the borderline and abnormal bands were 12.8% for Emotional Symptoms, and 23.7% for Peer Problems. The percentages were 14.2% for Conduct Problems and 13.2% for Hyperactivity. The percentage of Malaysian children within the abnormal and borderline band for the Prosocial was 16.0%. The current study did not find any differences in age and gender for Emotional Symptoms, Peer Problems, Conduct Problems and Hyperactivity. Nonetheless, Prosocial had significant effect for age. Conforming to previous studies, the findings also revealed that Total Difficulties scores (comprising the scores for Emotional Symptoms, Peer Problems, Hyperactivity and Conduct Problems), and the scale scores for Emotional Symptoms, Peer Problems, Hyperactivity and Conduct problems were all positively and significantly associated with parental rejection, and negatively and significantly associated with parental warmth. Prosocial was negatively correlated with parental rejection and positively correlated with parental warmth. The findings provide important new data on the behavioural and emotional problems of Malaysian school-aged children, and how these problems are associated to parenting styles. It also provided used normative data that can facilitate the use of the SDQ for screening behavior and emotion problems in Malaysian children.



Mental health is an important contributing factor for general health (Neugebauer, 1999). The importance of mental health has also been widely recognized. Recently, there has been greater interest in the epidemiology of childhood psychopathology. Many studies related to childhood mental health have been reported (Bird, 1996; Costello, 1989; Hoven et al. 2008; Marzocchi et al., 2004; Patel, Flisher, Hetrick, & McGorry, 2007; Roberts, Attkinson, & Rosenblatt, 1998). This is due to the realization that most mental health problems are rooted in early childhood experiences and tend to persist into adulthood (World Health Organisation [WHO], 2008).

As adult psychopathology has its origin in childhood, proper early intervention is essential in order that resultant disorder causing greater additional costs in adulthood can be avoided. This includes emotional and financial burden to the family, society and nation (WHO, 2008). A survey in the United Kingdom revealed that the cost of treating and managing mental disorders in the country was the highest compared to other major chronic conditions such as diabetes, breast cancer, hypertension and heart disease (National Health Survey [NHS], 1996). Role function was found to be more affected by mental disorders in childhood and adulthood than the other chronic illnesses (Kessler, Greenberg, Mickelson, Meneades & Wang, 2001; Murray & Lopez, 1996; Ormel et al., 1994; Wells, 1989). A survey of the literature revealed that up to 45% of absenteeism from work and deteriorating work performance was due to mental health problems (Patel & Knapp, 1997; Kessler & Frank, 1997; World Health Organisation [WHO], 2003)

Most childhood behavioural problems have disabling lifelong consequences not only on the child but also on the society. Previous findings showed that nearly 20% of children suffer from disabling mental illness (WHO, 2001). However, only

few received the necessary care and treatment (World Psychiatric Association [WPA], 2008). World Health Organization predicts that childhood neuropsychiatric disorder will rise by 50% by the year 2020 and will become one of the five most common causes of morbidity, mortality and disability among children (WHO, 2001)

Based on a systematic literature review, Belfer and Shatkin (2004) found only 7% of countries worldwide had a clear child and adolescent mental health policy. All these countries were western developed countries. Specific child and adolescent mental health policy were near to nonexistence in non-western developing countries. In a WHO report, it was reported that budgets for mental health care and services were lowest in African and South-East Asian countries (World Psychiatric Association [WPA], International Association for Child and Adolescent Psychiatry and Allied Professions [IACAPAP] & World Health Organization [WHO], 2005).

Due to the lack of systematic data, poor socio-economic growth and development, most of the developing non-western countries are at a greater disadvantage of proper mental health services, inadequate treatment and lacking systematic information for mental health program development (WPA, IACAPAP & WHO, 2005). Unfortunately, studies and awareness related to epidemiology of childhood mental health is still limited (Hoven et. al., 2008; Miranda & Patel, 2005; WHO, 2004). Furthermore, available published data are mostly concerned with the western population (Bird, 1996; Roberts, Attkinson & Rosenblatt, 1998; WPA, IACAPAP & WHO, 2005).

Nonetheless, as greater awareness is raised on the importance of epidemiological data, the past few decades have seen an increased in epidemiological studies of child psychopathology in the non-western population (Giel et al., 1981; Matsuura et al., 1993; Tadesse, Kebede, Tegegne & Alem, 1999; Thabet & Vostanis,

1998; Wong, 1988). Growing literature has contributed towards a better understanding in the area of childhood psychopathology. Theories and different approaches have been proposed to further define and conceptualize childhood mental and behavioral problems (Achenbach, 1991; Achenbach, 1993; Sroufe, 1997).

Mash and Dozois (2003) reported that one of the most common approaches in conceptualization of childhood psychopathology is the dimensional approach. Studies have identified two broad dimensions of child psychopathology – (1) externalizing behaviours and (2) internalizing behaviours (Reynolds, 1992). The externalizing dimension is behaviours that are considered as directed towards others (e.g. conduct problems and hyperactivity); while the internalizing dimension is described as states that are considered to be “inner-directed” (e.g. emotional problems) (Mash & Dozois, 2003, p. 27). Within the two broad dimensions of externalizing and internalizing disorders are specific subdimensions which include withdrawn, somatic complaints, anxious/depressed, social problems, thought problems, attention problems, delinquent behavior and aggressive behavior (Achenbach, 1993).

Based on this approach to the conceptualization of childhood psychopathology, assessment tools were designed to tap into these commonly identified dimensions of childhood behavioural problems. Epidemiological researches of child and adolescent mental health disorders have used a number of different methods and assessment tools in data collection. Metltzer, Gatward, Goodman & Ford (2000) reviewed several assessment tools commonly employed for a first stage, screening process in community-based studies of children disorders. Of the several assessment tools available, they found the most utilised and efficacious tools were Goodman’s Strengths and Difficulties Questionnaire, SDQ, (Goodman

1997), the Rutter Scales (Rutter, Tizard, & Whitmore, 1970) and the Child Behaviour Checklist (Achenbach and Edelbrock, 1983).

Similarly, Srinath, Kandasamy and Golhar (2010) collated and reviewed nonclinical-based English literature on epidemiological studies conducted in Asian countries. Based on the search, they found that the studies conducted were generally single-stage studies and used screening instruments such as the Child Behaviour Checklist (CBCL) (Achenbach, 1991), Strengths and Difficulties Questionnaire (SDQ) (Goodman, 2001) and Development and Well Being Assessment (DAWBA) (Goodman, et al., 2000) and the Diagnostic Interview Schedule for Children (DISC) (Shaffer et al., 1996). Nonuniformity of instruments used to measure the epidemiology of child and adolescent mental health within the Asian countries causes difficulty in conducting data comparison across different studies and different culture across different countries (Srinath et al., 2010).

Srinath et al. proposed that the Strengths and Difficulties Questionnaire (SDQ) or the Child Behaviour Checklist (CBCL) to be used as the instrument for a first stage prevalence research study on measuring behavioural problems of children and adolescents. Both the SDQ and the CBCL have been widely used in a variety of setting including epidemiological and clinical research as well as for routine clinical screening. Both the instruments examine the broad constructs of the different dimensions of child psychopathology and have been continuously proven to have good psychometric properties (Novik, 1999). Studies have also shown that the SDQ and CBCL are highly correlated and equally able to distinguish between the community and clinic sample. However, the SDQ showed significantly better results and was found superior as a measure of inattention/hyperactivity (Klasen et al., 2000; Goodman & Scott, 1999).

Goodman (1997) had developed the Strengths and Difficulties Questionnaire (SDQ) to address limitations of the previous measurements (Goodman, 1997). The SDQ is shorter, compact to just a sheet of paper, include strengths as well as difficulties items and has identical questionnaire for both parents and teachers (Goodman, 1997). The SDQ has been translated into 60 different languages including Malay, Tamil and Cantonese and used across different cultural context (Leung & Wang, 2003; Marzocchi et al., 2004; Mellor, 2005 Obel et al. 2004). Due to its brevity, simple administration and scoring technique, availability of several translated versions and easy access, the SDQ has become one of the most widely used childhood psychopathology measurement (Vostanis, 2006). It is a useful and practical instrument for large epidemiological research studies and suitable for screening large groups of low-risk children (Klasen et al., 2000).

The SDQ was developed as a brief screening tool that was based on the current classification of childhood mental health disorders. Its four difficulties subscales correspond to the broad constructs of emotional symptoms, peer problems, conduct problems and hyperactivity. Based on the dimensional approach to the conceptualisation of childhood psychopathology, the emotional symptoms and peer problems subscale represents the 'internalising' dimension of behavioural problems while conduct problems and peer problems represent the 'externalising' dimension of the behavioural problems (Goodman, Lamping & Ploubidis, 2010). Goodman et al., (2010) proposed that the dimensional approach to interpreting children behavioural problems would be the more conservative approach especially in epidemiological studies that involve a low-risk sample.

Studies have shown that the SDQ can be applied and interpreted across different cultures and settings. For example, Woerner et al., (2004) had reported an

overview of studies that have used the SDQ in non-European countries across different continents. They included studies from South America, Canada, Middle East, Asia and Australia. The SDQ has received increasing use throughout these continents. The SDQ was used as a screening tool to compare the prevalence rate of childhood behavioural problems across three regions in Brazil (Fleitlich-Bilyk, 2004). In Canada, with its easily accessible translated versions, the SDQ has further been proven to be a relevant screening tool within a multicultural context (Martinussen & Tannock cited in Woerner et al., 2004). Both studies in Yemen (Woerner et al., 2004) and Bangladesh (Goodman, Renfrew & Mullick, 2000) have further supported the validity of the SDQ in discriminating between a community and clinical sample. Furthermore, researches in Pakistan (Samad, Hollis, Prince & Goodman, 2005) and Thailand (Woerner et al., 2007) have further supported the applicability of the SDQ within a different cultural context. While in Australia, the SDQ has been widely used across the nation not just as a research tool but also as a nation-wide screening tool (Mathai, Anderson & Bourne, 2002).

Goodman (1997) had proposed convenient classification cut off scores for detecting and identifying children at risk of mental health disorders when using the SDQ. Based on previous findings, Goodman concluded that the cut off scores may vary with age, gender and the culture it is being assessed. Thus, with further clinical and epidemiological studies, Goodman suggested researchers to choose and adjust cut off scores according to the sample that is studied. Using this guideline, several studies have proposed new cut off scores according to the sample being assessed (Bourdon, Goodman, Rae, Simpson & Koretz, 2005; Mellor, 2005; Thabet, Stretch & Vostanis, 2000; Woerner et al., 2007). This has allowed valid cross-cultural

assessments and comparisons to be made (Verhulst & Achenbach, 1995; Marzocchi et al., 2007; Woerner et al., 2004).

Due to its free accessibility and effectiveness, the SDQ has been widely utilised in many Asian countries where health funding are scarce. Asian countries that have used the SDQ to obtain the rate and distribution of childhood behavioural problems include Afghanistan (Panter-Bricka, Eggermana, Gonzalezb & Safdarc, 2009), Yemen (Alyahri & Goodman, 2008), Pakistan (Syed, Hussein & Mahmud, 2007), Bangladesh (Mullick & Goodman, 2005) and Vietnam (Amstadter et al., 2011). This has generated greater awareness on the importance of mental health in these Asian countries.

Rates of community based samples were reported to be as low as 9.1% amongst 11-18 year olds in Vietnam (Amstadter et al., 2011), 9.4% amongst 8-12 years old in Kerala (Hackett, Hackett & Bhakta, 1999) and 15.0% amongst 5-10 years old in Bangladesh (Mullick & Goodman, 2005). However, school- based samples revealed higher rates of behavioural problems with a 15.7% rate amongst 7-10 year old school children in Yemen (Alyahri & Goodman, 2008), 22.2% amongst 11-16 year old school children in Afghanistan (Panter-Bricka et al., 2009) and 34.4% amongst 5-11 year old school children in Pakistan (Syed, Hussein, & Mahmud, 2007) .

One of the first epidemiological surveys of mental disorders among Malaysian children was conducted among school-based community children in a Malaysian village. The study was a two-staged study that involved initial screening and follow-up interview. Kasmini et al. (1993) reported that out of 507 children aged 1 to 15 years old, 6.1% had a diagnosable mental disorder. In another study, Zakaria and Yaacob (2008) conducted a prevalence study on orphanage children in a

Malaysian village and found that 8.2% of the sample had clinical psychiatric disorders. However, no prevalence studies have been conducted in Malaysia using a wider community based sample. Lack of mental health statistics is one of the greatest problems in Malaysia.

Epidemiological data on the prevalence of children with mental health problems in Malaysia is limited. Epidemiological studies of children's mental health are important as they allow rates and distribution of child psychopathology in the population to be determined (Bird, 1996). The findings from epidemiological studies can improve our knowledge on the incidence and aetiology of childhood behavioural problems. Similarly, potential risk factors that may contribute towards the problem specific to the current population and culture could be identified. The same information allows the understanding of the aetiology, the course and treatment outcome (Costello, Burns, Angold, & Leaf, 1993). All information gathered will be valuable in planning preventive and treatment services for that particular community or country.

Prior to last two decades, Malaysia had no clear identifiable national mental health policies or programs (Shatkin & Belfer, 2004). Mental health prevention and treatment services were close to non-existence. Nonetheless, with growing knowledge on the importance of the area, Malaysia has started to develop programs and national health policies that recognize the mental health problems in adults. This in which would have impacted directly or indirectly to a beneficial impact on children and adolescents mental health (Shatkin & Belfer, 2004). This indeed signifies a promising future for mental health of children and adolescents in Malaysia.



There is a large gap in the knowledge of the level of childhood mental health in Malaysia and the need for mental health services in children and adolescents. The same information allows us to understand about causation, course and treatment outcome (Costello et al., 1993). Without conventional epidemiological data, it is not possible to create awareness among policy makers, professionals and other stakeholders on the seriousness of the problem. As a consequence, mental health services and treatment programs are not provided or made available. This will result in an increase in undetected and untreated mental health problems in children.

Examining the incidence of childhood behavioural problems allows greater opportunities to conduct cross-cultural epidemiological studies. Cross-cultural studies allow rates and distribution of childhood mental disorders to be compared in different cultural settings across different nations. Specific factors such as cultural or social aspect that is related to childhood psychopathology can be determined and causes and aetiology of the disorder could be explored further.

A good understanding of the incidence of childhood behavioural problems, effective intervention and treatment plan, adequate service delivery and health policy can be developed to overcome the problem. Ultimately, with the increase in the awareness among health decision-makers and the general public, programs that are targeted and tailored specifically for the population of a particular country such as Malaysia can be designed and implemented. This indeed would allow greater outcome for better mental health amongst the children of that particular country (Bird, 1996). Unfortunately, in relation to the Malaysian children a sound epidemiological data related to behavioural problems is close to non-existence (WPA, IACAPAP & WHO, 2005).

Even though a translated version of the SDQ in Malaysia's national language i.e. Malay language is available, to date there are limited research that has utilised the SDQ in measuring the prevalence of childhood behavioural problem in the general Malaysian population. Some of the studies had used the SDQ as a secondary or outcome measurement to assess the level of psychopathology in relation to other issues. This includes relationship between childhood behavioural problems and childhood cruelty to animals (Mellor, Yeow, Mamat, & Mohd Hapidzal, 2008), parental belief on filial piety in Malay families (Ismail, Jo-Pei & Ibrahim, 2009) and the family environment and functioning (Taha et al., 2005). Most of the studies involved a small sample from one ethnic group of a multi racial population. Thus it is not a representative sample of the Malaysian population.

Childhood behavioural problems have been associated with several different factors such as socioeconomic status (Keenan, Shaw, Walsh, Delliquadri, & Giovannelli, 1997), stressful-life events (Garmezy, Masten & Tallegen, 1984), attachment (Bowlby, 1988, Rutter, 1995) and parenting styles and behaviours (Sigel, McGillicuddy-De, & Ann, 2002). Of the various factors mentioned, parenting styles and parenting behaviours have always been found to play a major role and closely associated with various child/adolescent behavioural problems. There are numerous studies regarding parenting and childhood behavioural problem within the Western population (Amato & Fowler, 2002; Bandura, 1986; Fiese, Wildern & Bickham, 2000; Rutter, 1995). However, studies in the Asian population are scarce. Parenting style in a Western context differs greatly from that of the Asians and at times can be almost opposite to each other (Greenfield & Suzuki, 1998; Holden, 1997). Based on the levels of control and warmth displayed by parents, Baumrind (1978) proposed four different parenting styles: authoritarian, permissive, authoritative and neglectful.

The authoritative style was found to be the best parenting style within the Western population whereas the authoritarian style brought about the best child behavioural outcome in Asian children. Conclusively, the cultural context in which the child is brought up influences child rearing and upbringing.

To investigate the influence of culture on parental behaviours, Rohner (1990) proposed the parental acceptance-rejection theory (PAR theory). PAR theory focuses on interpreting parenting behaviour in the form of perceived acceptance and rejection through the individuals' cultural lenses (Rohner, 1990). Rohner developed Parental Acceptance and Rejection Theory (PARTheory) based on the theory of "socialization and lifespan development" (Rohner, 1986). Parental acceptance and rejection represents a continuum scale of the warmth dimension of parenting. At one end of the continuum is parental acceptance – involving parental care, affection, nurturance and support. The other end of the continuum positions parental rejection – the absence of parental acceptance. Studies have shown that parental rejection can be expressed within these four dimensions: (1) cold/unaffectionate, (2) hostility/aggression, (3) indifference/neglect, and (4) undifferentiated rejection (Rohner, Khaleque, & Cournoyer, 2005). Based on the PAR Theory, Rohner & Rohner (1980) developed the Parental Acceptance Rejection Questionnaire (PARQ) to assess individual perception of parental behavior based on these four dimensions of parental rejection.

Rohner et al. suggest that parental acceptance and rejection can be viewed in two perspectives; from the phenomenological perspective as experienced by the individual and, from the behavioural perspective as viewed by observers close to the individual. Generally both perspectives reach the same conclusion (Rohner et al., 2005). Different versions of the PARQ were developed to address these different

perspectives. The versions include an individual reflection of their parents' parental behaviour (adult version) and individual perception of their own parental behavior (parent version). The current study focuses on the latter i.e. the experience of the parental acceptance and rejection from the perspective of the observer (i.e. parents and carers) using the parent version of the PARQ.

This theory has been widely developed and studied. Approximately 400 studies have been carried out across 60 nations (Rohner et al., 2005). The theory proposed the importance of the need for parental affection, care, comfort, support and nurturance (acceptance) in childhood. Positive behaviours were found to be related to warmth, care and closeness (Kendal & Morris, 1991). However, when this need for positive response is not met, there is a great tendency for the child to develop psychological problems (both internal and external).

Previous studies observed that the degree of the child's perception of rejection accounts up to 26% the variability of the child's psychological well-being and 21% in adulthood psychopathology (Rohner et al., 2005). Children who were perceived to be rejected or lacking acceptance from parents were found to have greater behaviour problems especially externalising behaviours such as aggressiveness, hostility, oppositional behaviours and conduct problems (Rohner et al., 2005). The literature supports the important role of parenting in the origin and development of both conduct problems and attention deficit hyperactivity disorders in children (Carlson & Corcoran, 2001; Johnston & Mash, 2001). A meta-analysis conducted by Loeber and Stouthamer-Loeber (1986) found that the dimensions of parental-child relationships such as parental involvement, supervision and rejection were among the most powerful predictors to conduct problems and delinquency. They also found that the dimensions of parental rejection were better predictors than

factors such as marital status and parental delinquency. Similarly, a study in England found that lack of parental involvement and warmth was associated with earlier convictions and higher delinquency behaviours in children (Farrington & Hawkins, 1991).

Previous studies have also suggested that the presence of attention deficit hyperactivity disorder (ADHD) in children is associated with parent-child interactions (Rutter & Sroufe, 2000; Johnston & Mash, 2001). For example, observational studies have found that children with ADHD were less compliant and exhibited more negative behaviours when mothers showed lack interaction and were more directive with less reward in their parenting (Danforth, Barkley & Strokes, 1991; Johnston & Mash, 2001).

Empirical studies have also shown that children with perceived parental rejection were likely to have negative distorted representations of not just their self but of others around them as well. Children with perceived parental rejection are more vulnerable to developing emotional and relationship problems (Rohner et al., 2005). For example, a longitudinal study over a 2 year period in China found that lack of parental warmth was associated with higher emotional and social adjustment in children (Chen, Liu & Li, 2000). Chen, Liu & Li concluded that insensitive and unresponsive parenting contributes toward the development of negative self view and emotional dysregulation in children (Chen, Liu & Li, 2000). Perceived parental warmth was found to be associated with initial level of social competence and predicted later social adjustment (Chen, Liu & Li, 2000).

Similarly, in another longitudinal study, Zhou et al. (2002) examined the association of parental warmth to children's social functioning and empathy-related behaviours. Their study found that across a two year period, parental warmth and

parental positive expressiveness was negatively correlated with externalizing behaviours and positively correlated with social competence and empathy related behaviours (Zhou et al., 2002).

There are also several studies that have looked at the association between parenting and prosocial behaviours in children. Studies show that parenting behaviours that exert care, affection and support which are behaviours that are intended to help and benefit others; provides a prosocial modeling for the child (Eisenberg & Fabes, 1998; Clark & Ladd, 2000). Thus, through positive modeling, children are influenced in exhibiting prosocial behaviours. In addition, Krevan & Gibbs (1996) found that parental warmth and support through the use of reasoning and inductive were found to be associated with greater prosocial behavior in their children.

The literature on the association of parenting and children's behavioural problem have contributed towards greater success of parent training programs with documented significant improvement in children's behaviours (Brestan & Eyberg 1998; Taylor & Biglan, 1998, Webster-Stratton, Reid & Hammond, 2004). Interventions have been designed to address these issues such as parent-focused programs that emphasizes on the importance of parental warmth, improving early child parent interactions and teaching better parenting skills (Saxena, Jane-llopis & Hosman, 2006).

Rohner (1986) proposed that parental rejection can be expressed through coldness/lack of affection (opposite of warmth and affection), hostility/aggression, indifference/neglect and undifferentiated rejection. Combination of these four parental rejection (or lack of parental acceptance) expresses the perceptions of

parental acceptance-rejection based on the continuum of the warmth dimension of parenting.

With findings from several cross-cultural studies, it was concluded that individual's perception of parental rejection are universally associated with childhood behavioural problems (Khaleque & Rohner, 2002; Rohner, Khaleque, & Cournoyer, 2005). Thus, it is expected that greater parental rejection would be associated with greater level of childhood behavioural problems for both externalising behaviours such as conduct problems and inattention and also internalising behaviours such as emotional difficulties and peer problems.

Currently there is little data on the prevalence of behavioural problems in the Malaysian children. Without any data on the types and frequency of childhood behavioural problems, understanding on the mental health issues related to Malaysian children and the knowledge on the areas that are in need of interventions and services will continue to be non-existent. Furthermore, awareness of the importance of child and adolescent mental health will not be raised and addressed. Further information of the level of children's mental health in Malaysia will further facilitate more effective ways of treating and overcoming the problem.

The way parenting behavior is related to child behavioural problems among the Malaysian population is also scarce. A comprehensive understanding of different behaviour problems and how they are associated with parenting behaviours would be critical for promoting better mental health services for children. This information is important as it allows cost effective planning and delivery of mental health intervention and prevention services for children in Malaysia. This indeed would contribute towards greater outcome for better mental health services in Malaysian children.

This study aims to shed light on the children's mental health status in the country. The main objective of this study was to use the SDQ to provide an estimate of the level of childhood behavioural problems in the Malaysian population. The current study focuses on providing types and frequency of childhood behavioural problems in a sample of school-aged children in Malaysia for Emotional Symptoms, Conduct Problems, Hyperactivity, Peer Problems and the overall behavioural problems. It will also examine the types and frequency of Prosocial behaviours within this sample. A secondary aim was to examine the relationship of the SDQ scores for Emotional Symptoms, Conduct Problems, Hyperactivity and Peer Problems and Prosocial with the PARQ scores for (1) warmth/affection, (2) hostility/aggression, (3) indifference/neglect, and (4) undifferentiated rejection in this sample. In light of previous theory and research, it is expected that the SDQ difficulties scores – Emotional Symptoms, Conduct Problems, Hyperactivity and Peer Problems, will have a positive relationship for each of the PARQ parental rejection scores – Hostility/Aggression, Indifference/Neglect, and Undifferentiated Rejection; and a negative relationship with the PARQ parental acceptance score i.e. Warmth/Affection. While Prosocial, the SDQ strengths scale, will have a negative relationship with Emotional Symptoms, Conduct Problems, Hyperactivity and Peer Problems; and a positive relationship with Warmth/Affection.



## Method

### Participants

Participant comprised of a randomly selected group of parents/primary caregivers of primary school children from Klang Valley, Malaysia. Two thousand five hundred parents/guardians of primary school children were invited to take part in the study. Participants were well informed of the aims and procedures of the study and their participation in the study was voluntary.

One thousand four hundred and seven participants responded giving a response rate of 56.3%. Participants' children's ages ranged from 5 to 13 years with a mean age of 9.87 ( $SD=1.80$ ). Out of the 1407 children, 616 were males ( $M_{age} = 9.80, SD= 1.79$ ) and 791 were females ( $M_{age} = 9.83, SD=1.81$ ).

Table 1 indicates the frequency of the child's age and race by gender. The frequency of the Malay and English version, and the nature of the relationship between the respondent and the child are also included in Table 1.

As shown in Table 1, the majority of the participants were Malays (52.3%) followed by Chinese (27.2%), Indian (16.0%) and others (1.2%). The current sample corresponds with the current ethnicity distribution of the Malaysian population ( $\chi^2(3) = 9.24, p > 0.01$ ).

Table 1

*Age and Race of Children by Gender and the Nature of Familial Relationship between Respondent and Child*

	Boys	Girls	Total
	N (%)	N (%)	N (%)
<i>Age</i>			
5	1 (0.2%)	1 (0.1%)	2 (0.1%)
6	13 (2.1%)	14 (1.8%)	27 (1.9%)
7	56 (9.1%)	75 (9.5%)	131 (9.3%)
8	102 (16.6%)	130 (16.4%)	232 (16.5%)
9	101 (16.4%)	91 (11.5%)	192 (13.6%)
10	81 (13.1%)	119 (15.0%)	200 (14.2%)
11	136 (22.1%)	169 (21.4%)	305 (21.7%)
12	106 (17.2%)	167 (21.1%)	273 (19.4%)
13	20 (3.2%)	25 (3.2%)	45 (3.2%)
	616 (43.78%)	791 (56.2%)	1407 (100.0%)
<i>Race</i>			
Malay	335 (54.4%)	401 (50.7%)	736 (52.3%)
Chinese	144 (23.4%)	237 (30.0%)	381 (27.1%)
Indian	106 (17.2%)	120 (15.2%)	226 (16.1%)
Others (e.g. Sikh, Indigenous)	8 (1.3%)	9 (1.1%)	17 (1.2%)
Not Indicated	23 (3.7%)	24 (3.0%)	47 (3.3%)
<i>Nature of Familial relationship between respondent and child</i>			
Mother	483 (78.4%)	639 (80.8%)	1123 (79.7%)
Father	103 (16.7%)	122 (15.4%)	225 (16.0%)
Others (older sibling/grandparent)	30 (4.9%)	30 (3.8%)	61 (4.3%)

As is reported in Table 2, the majority of both mother's (40.3%) and father's (65.3%) monthly income was more than RM 1500. Education in parents ranged from no formal education (0.6%) through to College/University educated (40.4% mothers,

42.2% fathers), with the majority of the parents (mother - 52.8%; father - 49.1%) had completed at least secondary school.

Table 2

*Descriptive Information on Monthly Income and Education Level of Mothers and Fathers of Children*

	Mother	(%)	Father	(%)
<i>Parental Monthly Income</i>				
Not Applicable	209	14.8	34	2.4
RM1-RM250	7	.5	0	0
>RM250-RM500	20	1.4	11	0.8
>RM500-750	24	1.7	32	2.3
>RM750-RM1000	50	3.5	86	6.1
>RM1000-RM1250	56	4.0	91	6.5
>RM1250-RM1500	77	5.5	130	9.2
>RM1500	568	40.3	921	65.3
Not Specified	399	28.3	105	7.4
<i>Parent's Highest Education</i>				
No Formal Education	9	0.6	9	0.6
Primary School	61	4.3	52	3.7
Secondary School	744	52.8	701	49.7
College/University	569	40.4	595	42.2
Not Indicated	27	1.9	53	3.8

## Measure

The survey instrument used consisted of three parts: (1) Background Information Questionnaire, (2) Strengths and Difficulties Questionnaire – Short form (SDQ) (Goodman, 1997), (3) Parental Acceptance Rejection Questionnaire (Parent PARQ-short) (Rohner & Khaleque, 2005). Parents were provided with both the Malay and the English versions of the survey instrument and given the choice of completing either the Malay or the English version. Approximately 831 parents completed the Malay version and 577 parents completed the English version.

*Background Information Questionnaire.* This is a semi structured questionnaire and consists of 9 questions (Appendix A (1)). It comprises information about the child's age, gender and ethnicity and the participant's (i.e. parents/caregivers) town/suburb of residence, household size, mother's and father's regular employment, mother's and father's monthly income and mother's and father's highest level of education.

*Strength and Difficulties Questionnaire – Short form* (Goodman, 1997). The Strengths and Difficulties Questionnaire (SDQ) is a brief screening instrument that was developed to assess children's behavioural problems. The SDQ is designed to be brief, applicable for children aged between 4 and 16 years with all 25 statements tapping into both children's strengths and difficulties (Goodman, 1997). The SDQ assesses children's behavioural problems within five subscales: Emotional Symptoms, Conduct Problems, Hyperactivity/Inattention, Peer Problems and Prosocial behaviour. Parents were provided with both the English version (Appendix A (2a)) and the Malay version (Appendix A (2b)) of the SDQ which were readily accessible from the website ([www.sdqinfo.com](http://www.sdqinfo.com)).

The items and the subscales were derived based on the current psychology and psychiatry concept of childhood psychopathology and factor analyses (Goodman, 1997; Goodman, 2001).

There are three versions of the SDQ; parent-informant, teacher-informant and self-report. For the current study, the short parent informant version of the SDQ was used. Parents were required to answer "Not True", "Somewhat True" and "Certainly True" to 25 statements. Twenty items were scored on a three point scale: 0-"Not true", 1-"Somewhat true" and 2-"Certainly true". The remaining five items were reverse-scored. A score for each subscale range from 0 to 10 and the sum of all four

subscales (except Prosocial scale) generates the Total Difficulties score that ranges from 0 to 40.

The reliability and validity of the SDQ have continuously been found to be satisfactory in studies of different communities across the world (Goodman, 1997; Goodman, 1999; Goodman et al., 1998, Goodman and Scott, 1999; Goodman, 2001; Klasen et al., 2000; Smedje et al., 1999). For example, Goodman (2001) reported mean internal consistency score of 0.73 for the parent SDQ within the UK sample. Cronbach alpha across all subscales (0.57 – 0.77) were generally satisfactory, with the highest internal consistency seen in Total Difficulties Scores (0.83) (Goodman, 2001). Similar findings were also found within large studies such as Australia (mean Cronbach alpha 0.73) (Mellor, 2004), Germany (mean Cronbach alpha 0.80) (Woerner, et al., 2004) and Sweden (mean Cronbach alpha 0.80) (Smedje et al., 1999).

For the current study, the overall SDQ items were reported to demonstrate Cronbach's alpha of 0.58. The Cronbach alpha coefficients for each subscale were 0.66 for Prosocial Behaviour; 0.55 for Hyperactivity/Inattention; 0.58 for Emotional Symptoms and 0.48 for Conduct Problems. The Cronbach alpha coefficient for Peer Problems was notably low (0.18). The Total Difficulties score scale had a higher alpha coefficient of 0.72. The internal consistency for the current study was comparatively low to Goodman's internal consistency (mean Cronbach  $\alpha$ - 0.73) (Goodman, 2001). Nonetheless, previous studies that have used the SDQ within the Malaysian population also found low to moderate Cronbach alpha (from 0.46 to 0.69) within their sample (Ismail, Jo-Pei & Ibrahim, 2009; Mellor et al., 2008; Mellor et al. 2010; Othman, Mohamad, Hussin, & Blunden, 2011; Taha et al., 2005).

*Parental Acceptance Rejection Questionnaire* (Parent PARQ-short) (Rohner & Khaleque, 2005). Parent PARQ-short consisted of a 24 item self-report instrument designed to measure parents' perceptions of their parental acceptance-rejection behaviour towards their child. The Parent PARQ-short is designed to tap into the individual's subjective interpretations and perceptions of parenting behaviour across four classes of common parental behaviours (Rohner, Khaleque & Cournoyer, 2009); warmth/affection (8 items), hostility/aggression (6 items), indifference/neglect (6 items) and undifferentiated rejection (4 items).

The Parent PARQ-short is scored within these four scales. Each individual would have to answer whether each statement was true or untrue about how the child is treated. If the statement was considered as true, he / she would further be asked "Is it almost always true?" or, "Is it only sometimes true?". Or if a statement was considered as untrue, they would further be asked, "Is it rarely true?" or, "Is it almost never true?". Twenty items were scored in a four point scale: 1-"Almost Never True", 2-"Rarely true", 3-"Sometimes True" and 4-"Almost Always True". Item 13 on the indifferent/neglect scale was reversed. Each item was then summed up within the four scales.

The total score for the warmth/affection scale is then reversed to make up the parental coldness/lack of affection scale. The Parent PARQ-short is scored in the direction of perceived rejection. Higher score indicates greater perceived parental coldness, hostility/aggression, indifference/neglect and undifferentiated rejection. The total score for each scale is summed up to represent the Total PARQ score. Total PARQ score falls between 24 and 96.

Both the English (Appendix A (3a)) and the Malay (Appendix A (3b)) versions of the Parent PARQ-short were provided. Permission to use the Parent

PARQ-short for the current research was obtained and accessed from the *Handbook for the Study of Parental Acceptance and Rejection*, 4th Edition (2005). The English version of the Parent PARQ-short was first translated to Bahasa Malaysia language by a native-speaking professor. Backward translation was then done by a Bahasa Malaysia-speaking, UK graduate professional officer. A provisional clinical psychologist, whose first language is Bahasa Malaysia, with equal proficiency in English then compared both versions of the back translation and the original English version of the Parent PARQ-short. Discrepancies were further discussed among the three translators involved and later modified to produce the final translated Bahasa Malaysia version of the Parent PARQ-short.

The Parent PARQ-short for the current study demonstrated Cronbach's  $\alpha$  coefficient of 0.73 for all of the 24 items of the Parent PARQ-short, 0.74 for warmth/affection scale, 0.69 for inattention/ neglect scale, 0.72 for hostility/aggression scale and 0.65 for undifferentiated/rejection scale.

## **Procedures**

This study was approved by the Tasmanian Social Sciences Human Research Ethics Committee. As the study was carried out in Malaysia, letters to seek permission to carry out the study were sent to the Research Promotion and Co-Ordination Committee, Economic Planning Unit (EPU), Prime Minister's Department. Once approval was given from EPU, further permission was required from the State Department of Education for both Federal Territory of Kuala Lumpur (WPKL) and Selangor. Permission was granted and the researcher was issued with permission letters and a research pass. Following the approvals, the lists of the government primary schools in the Klang Valley region including the schools'

addresses and contact numbers were obtained from the Selangor and WPKL Departments of Education.

According to the Department of Statistics Malaysia (2010), the 2010 midyear population census showed the Klang Valley population was 26% of the total Malaysian population of 28.5 million. Due to the Klang Valley's considerably large geographical area and population density, multi-stage random sampling technique was used in the selection of schools. Multi-stage random sampling is often used in large epidemiological studies (Calmorin & Calmorin, 2007). This technique involves dividing the sampling frame into a hierarchy of units and random sampling is conducted consecutively in every stage. It begins by dividing the population into large sample size referred to as *first-stage units*. Then, the *first stage units* are further divided into smaller samples i.e. *second-stage units*. This is followed by subdividing the second-stage into smaller units called *third stage-units* until the *ultimate unit* or sample is achieved (Das, 2009). In order to maintain the true simple random sampling in each stage, probability proportional to size is maintained. In this case the probability proportional to the number of schools for each stage unit is preserved (Dorofeev & Grant, 2006).

In the first stage, districts and zones located in the Klang Valley region were divided into two *first stage units*; (1) the state of Selangor and (2) the Federal Territory of Kuala Lumpur. In the next stage, two out of the four Selangor districts and one of the four WPKL zones that constitute Klang Valley were randomly chosen to be included in the study. The *second stage units* were the Petaling districts, Hulu Langat districts and Bangsar zone. There were a total of 269 schools from the *second stage units* (50% from Petaling district; 32% from Hulu Langat district; 18% from Bangsar Zone).



Based on the list of the school postcodes, nine schools from Petaling district, six schools from Hulu Langat district and three schools from Bangsar zone were selected using a random number generator. Eighteen primary schools in the Klang Valley region made up the *ultimate units*. Principals of the selected schools were contacted to further determine their interest in participating in the study. Out of the 18 schools contacted, fourteen agreed to receive information regarding the study. Finally, 12 schools agreed to participate. The flow chart for the selection procedure is diagrammatically shown in *Figure 1*.

For each school which expressed interest in the study, an information package was forwarded. An information package contain a copy of the approval from the University of Tasmania Ethics Committee (Appendix B), a copy of the approval from the Economic Planning Unit, Malaysia (Appendix C), a copy of the approval from the State Department of Education – approval from the State Department of Education for WPKL (Appendix D) or approval letter from State Department of Education for Selangor (Appendix E), a letter to the principal (Appendix F(1) – letter in English, F(2) –letter in Malay), a copy of the plain language statement for principals (Appendix G(1) – plain statement for principals in English, G(2) –plain statement for principals in Malay), a copy of the plain language statement for parents/guardians (Appendix H(1) – plain statement for parents/guardians in English, H(2) –plain statement for parents/guardians in Malay), and the measures to be used in the study (Appendix A) were forwarded.

Principals of schools that agreed to participate were contacted to further determine the appropriate time for the student researcher to visit the schools to distribute the questionnaire. With the principal's permission, an appropriate number of envelopes were personally distributed by the student researcher to the teachers to

be given to each child in their respective grades and to be forwarded to the child’s parent /primary caregivers. Each of these envelopes contained a copy of the plain language statement for parents/guardians, a background information form, the Strengths and Difficulties Questionnaire Parent-Short (SDQ) and the Parental Acceptance and Rejection Questionnaire Parent- Short (PARQ).

Parents/guardians were asked to return the completed questionnaires to the teachers through their children. The student researcher then collected the completed envelopes from the schools. All costs and materials for the study were borne by the researcher.

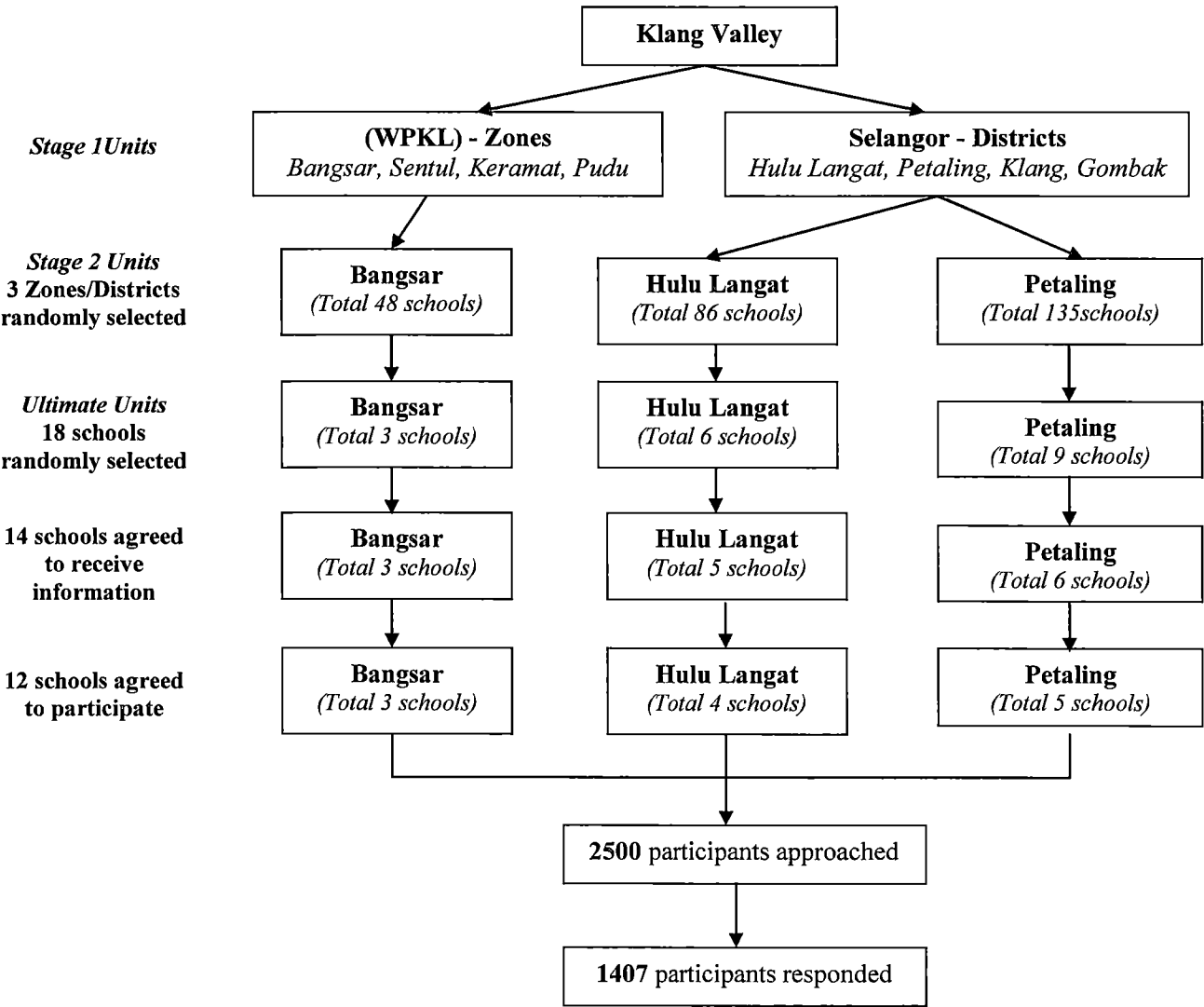


Figure 1. Flow chart of multiple random sampling

## **Results**

### **Types and Frequency of Behavioural Problems in Malaysian Children**

The rate of abnormal and borderline behaviours for five of the subscales of the SDQ: Emotional Symptoms (ES), Peer Problems (PP), Hyperactivity (H), Conduct Problems (CP), Prosocial(PS) and Total Difficulties scores (TDS) are calculated according to the cut-off scores proposed by Goodman (1997) (see Table 4). The cut off scores proposed by Goodman (1997) were designed to identify approximately 80% of children to be within the normal band, 10% within the borderline band and 10% within the abnormal band.

Out of the 1407 children, 21.3% of them had Total Difficulties scores within both the abnormal and borderline bands. There was an inflated rate of 44.6% for children within the abnormal and borderline bands for Peer Problems, followed by 29.1% for Conduct Problems and 23.4% for Emotional Symptoms. In contrast, the percentage of children within the abnormal and borderline band for Prosocial behaviours (16.1%) and Hyperactivity (12.9%) were below the estimated 20% range proposed by Goodman (1997).

The frequency of behavioural problems within the abnormal and borderline bands for Peer Problems, Conduct Problems and Emotional Symptoms were highly inflated and over inclusive. Thus, new adjusted cut off points are proposed.

Based on the cumulative frequencies distribution of the Malaysian sample, scores were separated to attain approximately 80% of the sample within the normal band and 20% within the abnormal and borderline bands. The cut off points (80<sup>th</sup>, 90<sup>th</sup>, 93<sup>rd</sup> and 98<sup>th</sup> percentiles) for each of the four difficulties of the SDQ subscales

and Total Difficulties scale are provided in Table 4. As Prosocial is a strength subscale, cut off points are reversed for this scale (20<sup>th</sup>, 10<sup>th</sup>, 7<sup>th</sup> and 2<sup>nd</sup> percentiles).

As shown in Table 3, out of the five SDQ subscales and Total Difficulties scores, only Hyperactivity and Prosocial retained the UK cut off scores for borderline and abnormal bands provided by Goodman (1997). Compared to the UK cut off scores, the proposed cut off scores for the Malaysian sample was higher for both the borderline and abnormal bands for Emotional Symptoms, Conduct Problems and Peer Problems. The borderline and abnormal cut off scores for Emotional Symptoms were 5 and 6, respectively, while both Peer Problems and Conduct Problems had the same cut off scores for borderline and abnormal (4 and 5, respectively). The proposed Malaysian cut off scores for Total Difficulties also had higher scores for both the borderline (15) and abnormal (18) bands as compared to the borderline and abnormal UK bands proposed by Goodman (1997) (14 and 17, respectively).

Table 3

*Malaysian cut off scores for each SDQ subscales and Total Difficulties scores*

	80 <sup>th</sup> percentile	90 <sup>th</sup> percentile	93 <sup>rd</sup> percentile	98 <sup>th</sup> percentile
Total Difficulties Scores	15	18	20	≥22
Emotional Symptoms	5	6	6	≥7
Conduct Problems	4	5	5	≥6
Hyperactivity	6	7	7	≥8
Peer Problems	4	5	6	≥6
Prosocial <sup>1</sup>	5	4	4	≤3

*Note* 80<sup>th</sup> percentile=Borderline band 90<sup>th</sup> percentile = Abnormal band. Scores equivalent or above the cut off scores are within the Borderline/Abnormal band. Borderline and Abnormal based on U.K. cut off scores are 4 and 5,3 and 4,6 and 7,3 and 4; and 14 and 17 for emotional symptoms, conduct problems, hyperactivity, peer problems and total difficulties respectively. Based on cut off scores proposed by Goodman (1997), cut off score for Prosocial is 5 and 4 Any score of below than 4 is within the Abnormal band and a score of 5 is within the Borderline band.

<sup>1</sup>Reversed cut off points applied for Prosocial scale. Cut off points at 20<sup>th</sup>, 10<sup>th</sup>, 7<sup>th</sup> and 2<sup>nd</sup> percentiles. Prosocial behaviour within the Borderline/Abnormal band indicates a lack of prosocial behaviour.

The frequency and types of behavioural problems based on the proposed Malaysian cut off scores are presented in Table 4. Based on the Malaysian cut off scores, the percentage of children within the borderline and abnormal bands were within the 20% range for all of the SDQ scales and Total Difficulties scores except for Peer Problems.

Table 4

*Percentage of children within the Borderline and Abnormal bands based on the UK cut off scores and Malaysian cut off scores for each subscale of the Strengths and Difficulties Questionnaire (SDQ) and Total Difficulties Scores*

	Percentage based on UK cut offs [95% Confidence Intervals]		Percentage based on Malaysian cut offs [95% Confidence Intervals]	
	Borderline	Abnormal	Borderline	Abnormal
Total Difficulties scores	12.3 [10.6, 14.0]	9.0 [7.5, 10.5]	9.5 [7.9, 11.0]	6.7 [5.4, 8.0]
Emotional Symptoms	10.9 [9.2, 12.5]	12.5 [10.8, 14.2]	7.2 [5.8, 8.5]	5.3 [4.2, 6.5]
Conduct Problems	15.0 [13.1, 16.9]	14.1 [12.3, 16.0]	8.4 [6.9, 9.8]	5.8 [4.8, 7.0]
Hyperactivity	8.2 [6.7, 9.6]	4.8 [3.7, 5.9]	8.2 [6.7, 9.6]	4.8 [3.7, 5.9]
Peer Problems	20.9 [18.8, 23.0]	23.7 [21.5, 25.9]	14.5 [12.7, 16.3]	9.2 [7.7, 10.7]
Prosocial	10.0 [8.5, 11.6]	6.0 [4.8, 7.3]	10.0 [8.5, 11.6]	6.0 [4.8, 7.3]

The percentage of children within the borderline and abnormal band based on the UK cut off scores and the proposed Malaysian cut off scores were the same for Hyperactivity and Prosocial scales. Percentage of children within both borderline and abnormal bands for Total Difficulties scores based on the Malaysian cut off scores

(9.5% and 6.7%, respectively ) were lower than the percentage of children within the borderline and abnormal bands based on the UK cut off scores (12.3% and 9.0%, respectively). Similarly, Emotional Symptoms and Conduct Problems also had lower percentages of children within the borderline and abnormal bands based on the Malaysian cut off scores compared to the percentages of children within the borderline and abnormal bands based on the UK cut off scores (see Table 4).

Unlike the other SDQ subscales, Peer Problems had more than the expected 10% range of children within the borderline band (14.5%) and had the highest percentage of children within the abnormal band (9.2%). Nonetheless, the percentage of children within both the borderline and abnormal bands for Peer Problems based on the Malaysian cut off scores were lower than the percentage of children within both the borderline and abnormal bands based on the UK cut off scores (20.9% and 23.7%, respectively).

### **Descriptive scores of each SDQ subscale and comparisons between the Malaysian and the British sample**

The mean and standard deviations for the SDQ subscales and Total Difficulties scores for the Malaysian and British sample are shown in Table 5.

In order to compare the difference between the Malaysian sample and the UK sample, a t-test analysis was conducted on each of the SDQ subscales and Total Difficulties scores, and presented in Table 5.

Overall, based on the parents report, the Malaysian children showed greater levels of behavioural problems than British children. The Malaysian children showed

higher level of Total Difficulties scores compared to the British children ( $M = 9.9$ ,  $M = 8.4$ , respectively). This difference was found to be significant,  $t(11703) = 9.28$ ,  $p < .001$ , with a small effect size ( $r = 0.14$ ).

Table 5

*Means and standard deviations, t-test value and effect sizes for the Malaysian and British sample*

SDQ Domains	Malaysian sample (N= 1407)		British sample (N=10,298)		<i>t</i> value	Effect Size <sup>1</sup>
	Mean	<i>S.D.</i>	Mean	<i>S.D.</i>		
Total Behaviour problems	9.9	4.8	8.4	5.8	9.28**	0.14
Emotional Symptoms	2.2	1.8	1.9	2.0	5.34**	0.08
Conduct Problems	1.9	1.5	1.6	1.7	6.29**	0.09
Hyperactivity	3.3	1.9	3.5	2.6	2.79*	0.04
Peer Problems	2.5	1.5	1.5	1.7	20.98*	0.30
Prosocial	7.6	1.9	8.6	1.6	21.47**	0.27

*Note.* *S.D.* = Standard deviation. \*\*  $p < 0.001$ , \*  $p < 0.01$ .

<sup>1</sup> An effect size of 0.2 represents a small effect, 0.3 as medium effect and more than 0.3 as large effect (Hemphill, 2003).

As seen in Table 5, the Malaysian children showed significantly higher levels of Emotional Symptoms and Conduct Problems compared to the British children, with small effect size ( $r = 0.08$ ,  $r = 0.09$ , respectively ). Similarly, Peer Problems also showed higher scores amongst the Malaysian children than the British children ( $M = 2.5$ ,  $M = 1.4$ , respectively,  $t(11703) = 20.98$ ,  $p < .001$ ,  $r = 0.30$ ). The

Malaysian parents reported significantly lower Prosocial behaviours for the Malaysian children compared to the British children ( $M = 7.6$ ,  $M = 8.6$ , respectively,  $t(11703) = 21.46$ ,  $p < .001$ ). This difference was found to have a medium effect size ( $r = 0.27$ ). On the other hand, the Malaysian parents reported lower level of Hyperactivity than the British sample ( $M = 7.6$ ,  $M = 8.6$ , respectively,  $t(11703) = 21.46$ ,  $p < .010$ ), with a minimal effect size ( $r = 0.04$ ).

### **Effects of age and gender on behavioural problems**

The mean scores and standard deviation for Emotional Symptoms, Peer Problems, Hyperactivity, Conduct Problems, Prosocial and Total Difficulties of boys and girls are presented in Table 6.

To examine the significance of the effect of gender and age on the SDQ subscales and the Total Difficulties scores, the study used a 2 (gender) x 3 (age: 5-7, 8-10, 11-13 years) analysis of variance (ANOVAs). Six ANOVA's were conducted for each SDQ subscales and Total Difficulties scores.

The main effects of the Emotional Symptoms for gender,  $F(1, 1401) = 0.711$ ,  $p = .399$ , age  $F(2, 1401) = 0.093$ ,  $p = .911$ , gender x age  $F(2, 1401) = 0.865$ ,  $p = .421$  were all found to be non significant.

The main effects of the Hyperactivity for gender,  $F(1, 1401) = 0.001$ ,  $p = .972$ , age  $F(2, 1401) = 0.191$ ,  $p = .826$ , and gender x age  $F(2, 1401) = 0.812$ ,  $p = .440$  were also found to be non significant.



The main effects of the Peer Problems for gender, age and gender x age interaction were  $F(1, 1401) = .948, p = .828$ ,  $F(2, 1401) = 1.383, p = .251$  and  $F(2, 1401) = 2.742, p = .065$ , respectively. All were also found to be non-significant.

Similarly, the main effects of the Conduct Problems for gender,  $F(1,1401) = 0.047, p = .828$ ; age  $F(2,1401) = 2.694, p = .068$ ; gender x age  $F(2,1401) = 2.742, p = .065$  were found to be non significant.

The main effects of Prosocial for gender and gender x age interaction,  $F(1,1401) = 0.869, p = .351$  and  $F(2,1401) = .1249, p = .287$ , respectively were also found to be non significant. However, the main effect of Prosocial for age was statistically significant,  $F(2,1401) = 7.147, p = .010$ . Children aged 11-13 years old showed the higher scores ( $M = 7.78, S.D. = 1.87$ ) for Prosocial compared to children aged 5-6 years ( $M = 7.22, S.D. = 1.95$ ) and children aged 8-10 years ( $M = 7.44, S.D. = 1.90$ ). The difference in scores were found to be significant between children aged 11-13 years and children aged 5-6 years,  $t(1404)=3.34, p < .05, d = 0.29$ . Likewise, the difference between children aged 11-13 years and 8-10 years was also found to be significant ( $t(1404) = 3.21, p < .05, d = 0.18$ ). However, no significant difference was found for Prosocial scores between children aged 5-6 years and 8-10 years,  $t(1404)=1.29, p = .20$ .

The main effect of the Total Difficulties Scores for gender,  $F(1, 1401) = 0.330, p = .566$ , age  $F(2, 1401) = 0.145, p = .865$ , and gender x age  $F(2, 1401) = 1.268, p = .282$  were all found to be non significant.

Table 6

*Mean and standard deviation scores for the Strengths and Difficulties Questionnaire (SDQ) domains based on gender and age*

SDQ Domains		All (N=1407)			Boys (N=616)			Girls (N=791)		
		5-7 y	8-10 y	11-13 y	5-7 y	8-10 y	11-13 y	5-7 y	8-10 y	11-13 y
Total Difficulties	Mean	10.11	9.86	9.81	9.67	9.76	10.06	10.46	9.94	9.63
	<i>S.D.</i>	4.83	4.87	4.87	4.61	4.70	5.01	5.00	4.59	4.76
Emotional Symptoms	Mean	2.31	2.23	2.22	2.11	2.21	2.26	2.47	2.24	2.18
	<i>S.D.</i>	1.89	1.79	1.85	1.99	1.81	1.81	1.80	1.77	1.88
Peer Problems	Mean	2.51	2.36	2.56	2.49	2.30	2.48	2.53	2.41	2.61
	<i>S.D.</i>	1.58	1.46	1.50	1.60	1.44	1.50	1.57	1.47	1.50
Hyperactivity	Mean	3.37	3.33	3.26	3.26	3.33	3.37	3.46	3.34	3.18
	<i>S.D.</i>	2.08	1.87	1.94	2.06	1.89	2.00	2.11	1.86	1.89
Conduct Problems	Mean	1.92	1.94	1.78	1.81	1.92	1.95	2.00	1.96	1.65
	<i>S.D.</i>	1.47	1.54	1.47	1.42	1.60	1.50	1.51	1.48	1.44
Prosocial	Mean	7.22	7.44	7.78	7.19	7.46	7.61	7.26	7.43	7.91
	<i>S.D.</i>	1.95	1.90	1.87	2.03	1.93	1.91	1.89	1.88	1.84

*Note.* y = years old. *S D* = Standard deviation

### **Relationship between SDQ Variables and Parental Behaviours**

In order to examine the relationship between childhood behavioural problems and parental behaviours in the Malaysian sample, Pearson correlation coefficients were calculated. Correlation coefficients of less than 0.2 are interpreted as small, 0.3 as medium and more than 0.3 as large (Hemphill, 2003).

As seen in Table 7, there are positive correlations between all of the behavioural problems of the SDQ subscales (Hyperactivity, Conduct Problems, Emotional Symptoms, Peer Problems and Total Difficulties score) and the parental rejection of the PARQ variables (Indifference/Neglect, Hostility/Aggression, Undifferentiated Rejection and Total PARQ). While, there are negative correlations between all of the behavioural problems of the SDQ subscales and the parental warmth of the PARQ variable (i.e. Warmth/Affection).

As expected, the Prosocial showed negative correlations with Indifference/Neglect, Hostility/Aggression, Undifferentiated Rejection and Total PARQ; and positive correlation with Warmth/Affection. All of the correlations were found to be significant at  $p < .001$ .

Based on Table 7, Warmth/Affection had small significant correlation coefficient magnitude with Emotional Symptoms and Peer Problems; and had medium significant correlation coefficients with Hyperactivity, Conduct Problems, Prosocial and Total Difficulties Scores. Indifference/Neglect also showed significant correlation coefficient

with small to medium magnitude ranging from 0.17 to 0.27. Similarly, Hostility/Aggression also showed significant small to medium correlation coefficient for each of the SDQ variables and Total Difficulties Scores.

Compared to other PARQ variables, Undifferentiated Rejection correlation coefficient magnitudes were mostly small except for Conduct Problems and Total Difficulties Score that had medium size correlation. Undifferentiated Rejection had a weaker relationship with the SDQ variables and Total Difficulties Scores.

Except for Undifferentiated Rejection, all of the PARQ variables were found to have larger effect sizes for both the externalising SDQ variables (i.e. Hyperactivity and Conduct Problems) compared to the internalising SDQ variables (i.e. Peer Problems and Emotional Symptoms).

Total PARQ scores were found to be significantly related to the SDQ variables as well as the Total Difficulties Scores, with medium to large effect size ( $r = 0.2$  to  $0.36$ ). Total PARQ was found to have the largest effect size with Total Difficulties scores followed by externalising SDQ subscales (Conduct Problems and Hyperactivity, respectively). Total PARQ scores were found to have lower effect sizes with internalising SDQ subscales (Peer Problems and Emotional Symptoms, respectively).

Thus, as previously reported, greater behavioural problems in children are associated with lack of parental warmth and affection and greater parental rejection.

Particularly, externalising behaviours were found to show greater association with parental rejection and lack of parental warmth compared to internalising behaviours.

Table 7

*Correlations SDQ variables and PARQ variables and descriptive statistics for each PARQ variables*

	Warmth/ Affection	Indifference / Neglect	Hostility/ Aggression	Undifferentiated Rejection	Total PARQ
Prosocial	0.29*	-0.18*	-0.17*	-0.13*	-0.27*
Hyperactivity	-0.22*	0.20*	0.23*	0.16*	0.27*
Conduct Problems	-0.27*	0.21*	0.24*	0.22*	0.32*
Emotional Symptoms	-0.13*	0.17*	0.16*	0.14*	0.20*
Peer Problems	-0.17*	0.17*	0.16*	0.18*	0.23*
Total Difficulties Score	-0.28*	0.27*	0.28*	0.24*	0.36*
Mean	28.5	10.7	11.1	6.8	40.1
S.D.	3.4	3.2	3.3	2.4	9.2
Range	8-32	6-24	6-23	4-15	24-76
$\alpha$	0.74	0.69	0.72	0.65	0.73

*Note* \* $p < 0.001$ , two-tailed.

## **Discussion**

The primary objective of the present study was to provide an estimate of the level of childhood behavioural problems (Emotional Symptoms, Conduct Problems, Hyperactivity and Peer problems) and strength (Prosocial) in the Malaysian population using the brief but widely employed Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). Data on childhood behavioural problem in Malaysia are scarce and previous studies have only focused on unrepresentative children population in Malaysia (Kashmini et al., 1993; Zakaria & Yaacob, 2008). Primary school children in Malaysia is compulsory, thus using a school sample will attain a better representation of Malaysian children and a reliable estimation of childhood behavioural problems in Malaysia. The current study investigated the level of childhood behavioural problems in a school-sample, representative of the children population in Malaysia's highest population density conurbation region. Types and frequency of emotional symptoms, conduct problems, hyperactivity, peer problems, prosocial behaviours and the overall childhood behavioural problems based on parental reports in a sample of school-aged Malaysian children aged between 5 and 13 years in the Klang Valley area were examined.

Another objective was to examine the relationship between the different childhood behavioural problems and self-reported parental behaviours in the form of perceived acceptance and rejection. This study assessed the relationship of the Malaysian children's level of Emotional Symptoms, Conduct Problems, Hyperactivity

and Peer Problems and Prosocial with parental rejection dimensions of Cold/Lack of Affection, Hostility/Aggression, Indifference/Neglect, and Undifferentiated Rejection.

### **Types and frequency of behavioural problems in Malaysian children**

The present study found that parents' report of their children's behavioural problems for Hyperactivity, Peer Problems, Emotional Symptoms and Conduct Problems to be higher within the Malaysian sample than that was found in the British sample reported by Meltzer, Gatward, Goodman, and Ford (2000). Malaysian parents also reported a higher level of lack of Prosocial behaviour. Overall, based on parental reports, behavioural problems in Malaysian children were found to be higher than the British sample.

Goodman (1997) recommended that specific cut off scores would need to be adjusted according to the different cultures and different samples. As the UK cut off scores proposed by Goodman were found to be over inclusive for the Malaysian population, in the present study new cut off scores for the Malaysian sample are proposed.

The new cut off scores for the Malaysian sample for borderline and abnormal bands were similar to those proposed by Goodman for only two scales, Prosocial (5 and 4, respectively) and Hyperactivity (6 and 7, respectively). The new proposed borderline and abnormal cut-off scores for Emotional Symptoms (5 and 6), Conduct Problems (4

and 5), Peer Problems (4 and 5) and Total Difficulties scores (15 and 18) were higher and narrower than those based on the U.K. cut off scores (4 and 5, 3 and 4, 3 and 4; and 14 and 17, respectively).

Based on the proposed Malaysian cut off scores, the overall behavioural problem within the borderline and abnormal band for Total Difficulties score were 9.5% and 6.7%, respectively. The percentages of internalising behavioural problems within both the borderline and abnormal bands were 12.8% for Emotional Symptoms and 23.7% for Peer Problems. Meanwhile, the percentages of externalising behavioural problems within both the borderline and abnormal bands were 14.2% for Conduct Problems and 13.2% for Hyperactivity for the Malaysian sample. The percentage of Malaysian children within both the abnormal and borderline band for the strength scale i.e. Prosocial was 16.0%.

In comparison, Goodman (1997) reported 20.0% of children were within both the borderline and abnormal bands for the Total Difficulties scores for the British sample of 10,298 children. Externalising behaviours for both the borderline and abnormal bands were found to be 23.6% for Conduct Problems; while 22.1% for Hyperactivity. On the other hand, internalizing behaviours within the British sample were 19.2% for both the borderline and abnormal bands for Emotional Symptoms; and a low percentage of 11.7% for both the borderline and abnormal bands for Peer Problems.

Overall, based on parent report, Malaysian children have a high percentage of children falling within both the borderline and abnormal bands for Peer Problems. In



contrast, Emotional Symptoms had a low percentage of Malaysian children reported to fall within both borderline and abnormal bands. Similarly, the percentage for Hyperactivity was also found to be low for both borderline and abnormal bands.

As studies that have assessed the prevalence rate of children behavioural problem within the Malaysian sample are scarce, comparison studies from existing Malaysian data are limited. Nonetheless, the percentage of children falling within both borderline and abnormal bands for Total Difficulties scores based on the Malaysian cut off scores concurs well with the findings of Kasmini et al. (1993). They observed that 6.1% of children between 1-15 years old in a Malaysian village had a diagnosable mental disorder which is comparable to the current sample that had 6.7% of children falling within the abnormal band for Total Difficulties scores.

However, the percentage of the current sample of children falling within the abnormal band for Total Difficulties score is lower than the 8.2% found by Zakaria and Yaacob (2008) in a sample of orphanage children in a Malaysian village. Due to greater risk factors for mental disorders that are associated with children and adolescent living in an orphanage, it is expected that the percentage of behavioural problems within their sample would be higher than the school-based community sample in this study. This is in agreement with previous findings (Oleke, Blystad & Rekdal, 2005; Rutter, 1999; Wolff & Fesseha, 2005).

### **Cross-cultural comparison of childhood behavioural problems**

The present study found that Malaysian parents reported behavioural problems in Malaysian children to be higher than the parent reports of British children for all of the SDQ scales. Nonetheless, the level of childhood and mental health problems in the present study were more comparable with that of non-western countries (Srinath, Kandasamy & Golhar, 2010).

The Malaysian children showed higher level of Total Difficulties scores compared to the British children ( $M = 9.9$ ,  $M = 8.4$ , respectively) especially for Conduct Problems and both internalising behaviours. Similar to the current study, several studies within the Asian countries also found higher Total Difficulties score than that was found within the British sample reported by Goodman.

For instance, a study of 1,965 school children aged 3 to 17 years old from 12 Shanghai districts in China had a mean of 10.5 for the Total Difficulties scores with the means of all the SDQ subscale scores higher than those of the British sample especially for the Peer Problem scale (Du, Kou & Coghill, 2008). Similarly, Total Difficulties score based on parental reports of 1,043 school children in Sri Lanka had a mean of 10.1 and reported a higher level of emotional symptoms and conduct problems than their U.K. counterpart (Prior, Virasinghe & Smart, 2005). Additionally, the mean for Total difficulties scores was 14.4 for 675 school children in Pakistan and similarly had significantly higher level of emotional and behavioural problems than U.K. (Syed, Hussein & Mahmud, 2007). Thabet, Stretch and Vostanis (2010) had similar findings of

over rated scores for Peer Problems and Conduct problems for a sample of Gaza children.

Interpretation and conceptualisation of behavioural and emotional problems differ between cultures. There are cultural differences in the prevalence, patterns and context of internalising behaviours and appropriate emotional outputs (Abu-Lughod & Lutz, 1990; Briggs, 1970) as well as externalising behaviours and child aggression (Deater-Deckard & Dodge, 1997). Thabet et al. (2010) reported that the interpretation within the western context can differ with the interpretation of the internalising symptoms for the non-western sample.

The significant differences between the Malaysian and British data may be due to parental and cultural expectations. The high level of behavioural problems reported by parents may indicate that Malaysian parents have higher standards and expectations set for their children. The over rated scores of behavioural problems can be attributed to the fact that Malaysian parents are more rigid with their children.

Cross-cultural research has found that parental expectations for their children differ with culture. There are also cultural differences in the degree to which parent focuses on their children's success and failures (Oishi & Sullivan, 2005). Many Asian, non-western countries practice collectivist values. There is greater emphasis on obedience to rules in a collectivist culture and rights of families and communities exceed the rights of the individual. Children are expected to regard parents as clear authority.

Children have filial obligations and are expected to behave in a certain manner conforming to the social expectation and reciprocity (Chao, & Tseng, 2002).

For example, Azuma, Kashiwagi & Hess (1981) found that Japanese parents emphasize emotional control, conformity and politeness in their children while the American parents encourage their children to promote self-expression in the hope of developing social skills. Chang (2002) found that Asian Americans had higher level of parental criticism and parental expectation than did the European Americans. These parental criticisms and expectations were found to contribute towards low levels of well-being in their children (Chang, 2002; Twenge & Crocker, 2002). Findings of cross-cultural studies have also revealed that Asian parents have high expectations and aspirations for their children (Chao, & Tseng, 2002; Chen & Stevenson, 1995, Hao & Bonstead-Bruns, 1998).

Studies have found that relative to European American, Asian parents had a greater tendency to focus on the children's failures than success and have a lower tolerance to behavioural problems in children (Dennis, Cole, Zahn-Waxler, & Mizuta, 2002; Miller, Wiley, Fung, & Liang, 1997). Mann et al. (1992) also found that Asian parents have lower threshold in identifying hyperactivity in their children while Weisz et al., (1987) reported Asian parents have lower tolerance to children's behavioural problem. Due to high expectations and being more likely to report failure or behavioural problems, Asian, non-western parents have a greater tendency to overrate the level of behavioural problems that their children have, more so than the western parents.

Conforming to this, epidemiological studies conducted in the western countries such as United States (Bourdon et al., 2005), Finland (Koskelainen, Sourander & Kaljonen, 2000), Germany (Woerner, Becker & Rothenberger, 2004) were all found to have mean scores lower than the British sample. For example, a normative study of behavioural children in the United States (Bourdon, Goodman, Rae, Simpson & Koretz, 2005) found a lower mean ( $M=7.1$ ) for Total Difficulties score than the mean of 8.4 as proposed by Goodman (1997).

A German nationwide survey found that parental report of the SDQ showed lower scores for inattention/hyperactivity and emotional symptoms than the UK sample and had a generally lower mean for all behavioural problems than the British sample (Woerner, Becker & Rothenberger, 2004). Additionally, Obel et al (2004) looked at the studies that have used the SDQ as a measurement tool in Europe. Obel et al. reported that studies in Denmark, Norway and Sweden had means ranging 5.7 to 7.2 for Total Difficulties scores in which were all below the mean of the British sample. Within a sample of 910 school children in Australia, a normative data for the SDQ also showed a slightly lower mean ( $M=8.2$ ) than that proposed by Goodman (Mellor, 2005).

This has further supported Goodman's suggestion on the importance of adjusting cut off scores according to the culture it is being assessed. By adjusting and proposing new cut off scores adapted to the sample it is assessed, the SDQ will reduce the likelihood for it to detect 'non-cases' and be too over inclusive of identifying a behavioural problem.

### **Relationship between childhood behavioural problems and parental behaviours**

This study revealed that behavioural problems were found to be positively associated with parental rejection and negatively associated with parental warmth. As expected, the Prosocial was negatively correlated with parental rejection and positively correlated with parental warmth. Parental warmth was found to have lower strengths with internalising behaviours and greater strengths with externalising behaviours and prosocial behaviour. Compared to other PARQ variables, Undifferentiated Rejection had a weaker relationship with the SDQ variables and Total Difficulties Scores. Except for Undifferentiated Rejection, parental rejection was found to have a stronger association for both the externalising SDQ variables compared to the internalising SDQ variables.

The finding that greater behavioural problems in children are associated with lack of parental warmth and affection and greater parental rejection confers well with previous reports (Clark & Ladd, 2000; Eisenberg & Fabes, 1998; Rohner et al., 2005). Externalising behaviours in particular were found to show greater association with parental rejection and lack of parental warmth, compared to internalising behaviours. Consistent with previous studies, the current study found that conduct problems had the strongest relationship with parental rejection (Loney & Milch, 1982; Farrington, 1978). Similarly, Farrington, Loeber & Van Kammen (1990) found that lack of parental involvement, supervision and attention were associated to both conduct problems and hyperactivity behaviours in children. Even so, these dimensions of parent-child

interactions were found to be more closely related to conduct problems than hyperactivity (Farrington, Loeber & Van Kammen, 1990).

In a collectivist culture like Malaysia, there is an emphasis on adherence to conventions and obedience. This is believed to be a necessity in perceiving group harmony and filial piety (Chao & Tseng, 2002; Triandis, 1995). Hostile, aggressive and impulsive behaviours that can potentially cause a disruption in the social harmony are considered to be strictly prohibited in a collectivist culture (Ho, 1986; Triandis, 1995; Lam, 1997). Behaviours that are not acceptable within the culture such as externalising behaviours are more likely to be associated with parental rejection and dismissal, especially for a collectivist culture like Malaysia.

Parents within a western, individualistic culture may exhibit more caution in describing their children. Non-western parents, especially Asian parents; with a collectivist culture may have a higher standard of expected behaviours in their children (Koskelainen, Sourander & Kaljonen, 2000). Asian parents are more likely to over rate their children's behaviour problems than would the parents within a western population. For example, a cross cultural comparison on child rearing practices between a collectivist country i.e. Korea and an individualist country i.e. Australia found that Korean mothers showed greater negativity and lack of involvement than the Australian mothers (Oh, Shin, Moon, & Hudson, 2002). Similarly, overrating of behavioural problems may indicate a high standard and lower tolerance levels applied by the parents in the Malaysian sample. Thus, due to the low level of tolerance, parents are less likely

to exhibit parental warmth and acceptance towards their children's behavioural problems.

## **Implications**

This study has provided information on the different types and frequency of childhood behavioural problems in Malaysia. The information presented allows a better understanding of the distribution of the childhood mental health problems within the Malaysian sample and provides a baseline data for future investigations.

As results concur with previous findings, both the Malay and English SDQ are efficient tools for screening and identification of childhood behavioural problems. Furthermore, free access to its translated versions opens more doors for studies on children and adolescent mental health to be conducted in Malaysia. Researchers are able to utilize the SDQ and generate hypotheses for future studies on childhood behavioural problems in Malaysia based on the current data. There is increasing efforts in the impact of mental health in children in Malaysia. Mental health services for children though limited are slowly growing. Thus, with further evidence of its construct validity and efficacy, measuring outcome of current and future children's mental health services can be done using the free Malay and English SDQ. The identification and screening can be further expanded to examine the different ranges of children's behavioural problems.



Additionally, the cut off points provided (80<sup>th</sup>, 90<sup>th</sup>, 93<sup>rd</sup> and 98<sup>th</sup> percentiles) can further assist clinicians or researchers in the determination of the need for further investigation. The 80<sup>th</sup> and 90<sup>th</sup> percentile cut off scores can be used for screening purposes while the more restrictive 93<sup>rd</sup> and 98<sup>th</sup> percentile cut off scores can be used for identification purposes (DuPaul et al., 1997). The present study has allowed greater utility of the SDQ in the Malaysian sample especially for identification of early mental health disorders or children at risk, or for the determination of acceptable referrals for a service.

This study has also contributed towards the cross-cultural research into child mental health problems in Malaysia. The current study had further demonstrated the effects of culture and the issues that arise from parental based reports. Thus, it is important that future utilisation of the SDQ for the Malaysian population to be weary of this issue.

This current study has further supported the construct validity of the SDQ as it was found to correlate moderately with the PARQ scales. This study has provided further cross-cultural evidence of parental warmth and its association with the different behavioural problems. Further understanding of the different parental rejection behaviours that endorse children behavioural problems have also guided interventions and preventive parent training programs to be adapted specifically to the Malaysian population.

Studies have found that not all parents and children benefit from interventions and parenting program if it is not tailored to the culture and the needs of the parent and child (Forehand & Kotchick, 1996; Sanders, 1992). As dimensions of parental rejection and lack of acceptance were found to be more closely related to conduct problems than hyperactivity, parenting programs can be designed to incorporate parental involvement, supervision and attention especially interventions for children exhibiting externalising behaviours. Information gathered utilizing this brief screening tool can facilitate the development of school intervention programs that focussed on child-family interactions to help reduce the level of conduct problem behaviour in the children (Taha et al, 2005).

Literature on the association of parenting and children's behavioural problem has its importance on its contribution towards greater success of prevention and intervention programs for children (Brestan & Eyberg 1998; Taylor & Biglan, 1998, Webster-Stratton, Reid & Hammond, 2004). Interventions are designed to address these issues such as parent-focused programs that emphasizes on the importance of parental warmth, improving early child parent interactions and teaching better parenting skills (Saxena, Jane-Ilopis & Hosman, 2006).

In a Malaysian study, Othman, Wee & Mohd Shahidi (2011) had used the SDQ as a screening tool and an outcome measurement to assess children behavioural and emotional problems pre and post intervention. They developed a cognitive behavioural social skills training for primary school Malaysian children with behavioural problems. Though there were some aspects of improvement in the children's behaviour, their study

failed to prove the effectiveness of the program within the Malaysian children. To further increase the probability of the success, information from the current study can further support future planning of prevention and intervention programs such as this. A program that emphasises the importance of parental acceptance/rejection and its strong relationship with externalising behaviours will produce a better and promising outcome. Furthermore, a better distribution of the childhood mental health problems within the Malaysian sample provides a baseline data for future investigations and planning.

### **Limitations & Future studies**

The current study has several limitations worthy of considerations. All the participating children were from a convenient sample of Malaysian school children within a metropolitan area. The current findings may not generalize to other rural part of Malaysia. It is also important to consider that some of the more severely disturbed children in the community may not attend school or are living in the rural areas (Mellor, 2005). It is important to note that a study in a Malaysian village found similar findings to the present study (Kasmini et al., 1993).

Another limitation of the present study is that it was based on a single informant report. The present study had only investigated the parent version of the SDQ. At the moment, there is only the parent and the teacher versions of the Malay SDQ available on the SDQ website. The Malay SDQ self report has yet to be translated to the Malay version. Further studies that utilises the teacher and self-report versions of the SDQ would be valuable.

Without a multi-informant report (i.e. parent, teacher and self-reports) and impact scores, prediction of diagnostic status of the Malaysian children were not examined (Goodman, 2000). The current study focused on providing information on the types and frequency of the behavioural problems in the Malaysian sample rather than as a diagnostic research of clinical impairment in the children. Furthermore, no analysis on parental demographic details was done in this study. It is recommended that it be address in future investigations.

Research have found gender differences in children's behavioural problems however, this study was not able to establish any gender differences in the sample. Further understanding of the effects of gender on the Malaysian children behavioural problems is recommended for future studies. It is also important to broaden the age range of the current study in order to take into account mental health problems across the different stages of childhood development (e.g. from pre-school to late adolescence). As Malaysia is a heterogeneous society that consists of three major races, it is also important that future studies investigate the effects of race on the distribution and prevalence the different childhood behavioural problems.

The internal consistencies in this study were found to be substantially lower than previous findings (Smedje et al., 1999). Studies from Sweden, Australia, United Kingdom and Germany all showed results with high internal consistencies. Previous studies that have used the SDQ within the Malaysian population also found low to moderate Cronbach alpha (from 0.46 to 0.69) within their sample (Ismail, Jo-Pei &

Ibrahim, 2009; Mellor et al., 2008; Mellor et al. 2010; Othman, Mohamad, Hussin & Blunden, 2011; Taha et al., 2005).

Several studies in different countries such as the Middle East, Sri Lanka and China have also found low internal consistencies especially for Peer Problems (Prior, Virasinghe and Smart, 2005; Thabet, Stretch & Vostanis, 2000). Similarly, in a sample of a multi-ethnic city in Norway, the study found lower internal consistency especially for Peer Problem (0.44) and Conduct Problems (0.46). This warrants for an investigation on the psychometric properties of the SDQ within the Malaysian population especially for the Peer Problem scale.

The translation of a measure to another language requires linguistic/semantic equivalence across cultures Leung and Wong (2003). The translated version should preserve the semantics and meaning of the original measurement accordingly. No existing studies have looked at the psychometric properties of the Malay version of the SDQ. There is also no description of how the Malay version of the SDQ provided at the website had achieved its linguistic/semantic equivalence. Furthermore, the utility of the English version of the SDQ have not been examined within the Malaysian population. There is a possibility that there could be a potential misinterpretation of test results in cross-cultural comparisons. The equivalence between the English and the Malay version of the SDQ has not been proven. This suggests a need for an equivalency test and further examination of the psychometric properties of the SDQ using factorial structure and reliability measures.

The SDQ is an effective economical screening instrument. However, future studies need to investigate and further improve the psychometric properties of the questionnaire. Future studies can further test the psychometric properties of the SDQ within the Malaysian sample by taking into consideration the limitations identified in the current study. Additional development and testing for the measurements used in the study can further validate the tools used.

In conclusion, the current study has provided data on different types and frequency of childhood behavioural problems in the Malaysian children. Cut off scores are also proposed for the use of SDQ not only for use for community screening but also for clinical evaluation. Being a brief and quick screening tool, its use will facilitate further research in areas of children behavioural problems amongst the Malaysian population. The accessibility of the SDQ and the availability of a translated version have facilitated further studies in this area and contribute towards a better understanding of children and adolescent mental health in Malaysia. This provides promising future for the intervention and prevention of psychopathology in Malaysian children. All information gathered will contribute towards an effective and meaningful planning of future mental health services for the Malaysian population

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## APPENDIX A (1)

Just fill in one section.  
Sila isi hanya satu seksyen.

### BACKGROUND INFORMATION FORM

Child's age: \_\_\_\_ Year \_\_\_\_ Month

Child's gender: F ☐ M ☐

Child's ethnic background (please tick one):

Malay ☐ Chinese ☐ Indian ☐ Other (Specify): \_\_\_\_\_

Town/Suburb of residence \_\_\_\_\_

Mother's regular employment \_\_\_\_\_

Mother's highest level of education \_\_\_\_\_

Father's regular employment \_\_\_\_\_

Father's highest level of education \_\_\_\_\_

Household size \_\_\_\_\_

Tick the appropriate boxes.

Parent's Monthly Income (RM)	Not Applicable	1-250	>250-500	>500-750	>750 - 1000	> 1000 - 1250	> 1250 - 1500	> 1500
Mother's Monthly Income								
Father's Monthly Income								

### SOAL SELIDIK LATAR BELAKANG KANAK-KANAK DAN SURAT KEBENARAN

Umur kanak-kanak: \_\_\_\_ Tahun \_\_\_\_ Bulan Jantina kanak-kanak: P ☐ L ☐

Latar belakang etnik kanak-kanak (sila tandakan satu):

Melayu ☐ Cina ☐ India ☐ Lain-lain \_\_\_\_\_

Bandar/ Kawasan tempat tinggal \_\_\_\_\_

Pekerjaan ibu \_\_\_\_\_

Tahap pendidikan tertinggi ibu \_\_\_\_\_

Pekerjaan Bapa \_\_\_\_\_

Tahap pendidikan tertinggi bapa \_\_\_\_\_

Bilangan ahli dalam keluarga: \_\_\_\_\_

Tandakan ruangan yang berkenaan.

Gaji Bulanan ibu/ bapa (RM)	Tidak berkenaan	1-250	>250-500	>500-750	>750 - 1000	> 1000 - 1250	> 1250 - 1500	> 1500
Gaji bulanan ibu								
Gaji bulanan bapa								

This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on +61 3 6226 7479 or email [human.ethics@utas.edu.au](mailto:human.ethics@utas.edu.au). The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number H11227.

# **APPENDIX A2(a)** **Strengths and Difficulties Questionnaire**

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behaviour over the last six months or this school year.

Child's Age \_\_\_\_\_ Years \_\_\_\_\_ Month

Male/Female

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restless, overactive, cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shares readily with other children, for example toys, treats, pencils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often loses temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rather solitary, prefers to play alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally well behaved, usually does what adults request	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many worries or often seems worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has at least one good friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often fights with other children or bullies them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generally liked by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted, concentration wanders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often lies or cheats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Picked on or bullied by other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinks things out before acting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steals from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gets along better with adults than with other children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Many fears, easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good attention span, sees work through to the end	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature .....

Date .....

Was this checklist completed by the mother? YES / NO

If NO, who completed this checklist?

Parent / Teacher / Other (Please specify): \_\_\_\_\_

Have you completed this checklist for another child? YES / NO

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**Thank you very much for your help**

APPENDIX 2(b)

Soal Selidik Kekuatan Dan Kesusahan (SDQ-Mal)

Bagi setiap perkara dibawah, sila tandakan petak Tidak benar, Sedikit Benar atau Memang Benar. Anda boleh membantu kami jika anda dapat menjawab semua soalan dengan sebaik yang boleh walaupun anda tidak pasti. Sila beri jawapan anda berasaskan kelakuan kanak-kanak itu dalam masa enam bulan yang lalu.

Umur kanak-kanak: \_\_\_\_\_ Tahun \_\_\_\_\_ Bulan

Lelaki/Perempuan

			Memang Benar
Bertimbang rasa terhadap perasaan orang lain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gelisah, terlalu aktif, tidak dapat diam untuk masa yang panjang.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selalu mengadu sakit kepala, sakit perut, atau berpenyakit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedia berkongsi dengan kanak lain (belanja, permainan, pensil)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selalu naik marah atau pemarah.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bersendirian, lebih suka bermain seorang diri.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biasanya taat, melakukan apa yang dikehendaki oleh orang dewasa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Banyak kebimbangan, selalu nampak bimbang.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suka menolong jika seseorang cedera, rasa terganggu atau tidak sihat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sentiasa bergerak dengan resah atau mengeliat geliut.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ada sekurang kurangnya seorang kawan baik.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selalu bergaduh dengan kanak kanak lain atau membuli mereka.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selalu tidak gembira, susah hati atau menangis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biasanya disukai oleh kanak kanak lain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mudah mengalih perhatian, penumpuan melayang layang.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gelisah atau lekat dengan orang dalam situasi baru, mudah hilang keyakinan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Baik kepada kanak kanak yang lebih muda.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Selalu berbohong atau menipu.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dibuli oleh kanak kanak lain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menawarkan secara sukarela pertolongan kepada orang lain (ibubapa guru, kanak kanak lain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Berfikir sebelum bertindak.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mencuri daripada rumah, sekolah atau lain lain tempat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mudah berbaik baik dengan orang dewasa daripada kanak kanak.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Banyak ketakutan, mudah takut.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Membuat tugas dari awal hingga ke akhir, jangka masa perhatian baik.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tanda tangan .....

Tarikh .....

Adakah soal selidik ini diisi oleh ibu? YA / TIDAK

Jika TIDAK, siapa yang telah mengisi soal selidik ini? \_\_\_\_\_

Adakah anda telah mengisi soal selidik ini untuk kanak-kanak lain? YA / TIDAK

Terima kasih atas bantuan anda

## APPENDIX A (3a)

### PARENTAL ACCEPTANCE-REJECTION QUESTIONNAIRE PARENT PARQ (Short Form)

Is it this questionnaire completed by the mother? ☐ YES ☐ NO

If no, who completed this checklist? Specify \_\_\_\_\_

The following pages contain a number of statements describing the way parents sometimes act toward their children. Read each statement carefully and think how well it describes the way you treat your child. Work quickly. Give your first impression and move on to the next item.

Four boxes are drawn after each sentence. If the statement is *basically* true about the way you treat your child then ask yourself, "Is it almost *always* true?" or "Is it only *sometimes* true?" If you think you almost always treat your child that way, put an *X* in the box ALMOST ALWAYS TRUE; if the statement is sometimes true about the way you treat your child then mark SOMETIMES TRUE. If you feel the statement is basically *untrue* about the way you treat your child then ask yourself, "Is it *rarely* true?" or "Is it almost *never* true?" If it is rarely true about the way you treat your child put an *X* in the box RARELY TRUE; if you feel the statement is almost never true then mark ALMOST NEVER TRUE.

Remember, there is no right or wrong answer to any statement, so be as honest as you can. Respond to each statement the way you feel you really treat your child rather than how you would like to treat her/him. For example, if you almost always hug and kiss your child when (s)he is good, you should mark the item as follows:

	TRUE OF ME		NOT TRUE OF ME	
	<i>Almost Always True</i>	<i>Sometimes True</i>	<i>Rarely True</i>	<i>Almost Never True</i>
I hug and kiss my child when s(he) is good	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



		TRUE OF ME		NOT TRUE OF ME	
		<i>Almost Always True</i>	<i>Sometimes True</i>	<i>Rarely True</i>	<i>Almost Never True</i>
1.	I say nice things about my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I pay no attention to my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I make it easy for my child to confide in me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I hit my child even when (s)he may not deserve it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I see my child as a big nuisance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I punish my child when I am angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I am too busy to answer my child's questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	I resent my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	I am really interested in what my child does	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	I say many unkind things to my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	I pay no attention to my child when (s)he asks for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	I make my child feel wanted and needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	I pay a lot of attention to my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	I hurt my child's feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	I forget important things my child thinks I should remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	I make my child feel unloved if (s)he misbehaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	I make my child feel what (s)he does is important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	When my child does something wrong, I frighten or threaten him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	I care about what my child thinks, and encourage him/her to talk about it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.	I feel other children are better than my child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	I let my child know (s)he is not wanted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	I let my child know I love him/her	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	I pay no attention to my child as long as (s)he does nothing to bother me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	I treat my child gently and with kindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## APPENDIX A (3b)

### SOAL SELIDIK PENERIMAAN - PENAFIAN IBU BAPA 'PARENT PARQ' (Ringkasan)

Adakah soal selidik ini diisi oleh ibu kanak-kanak ? ☐ YA ☐ TIDAK

Jika tidak, siapakah yang telah mengisi soal selidik ini?

\_\_\_\_\_ ( Hubungan dengan Kanak-kanak)

Muka surat berikut mengandungi beberapa kenyataan menerangkan layanan biasa ibubapa terhadap anak-anak mereka. Baca tiap-tiap kenyataan dengan teliti dan fikirkan sejauhmana ia menerangkan aksi anda melayan anak anda. Lakukan dengan cepat. Berikan pendapat pertama anda dan teruskan ke kenyataan seterusnya.

Empat kotak disediakan selepas tiap-tiap ayat. Jika pada *asasnya* kenyataan mengenai cara anda melayan anak-anak anda itu benar, kemudian tanya diri anda; “Adakah ia *hampir sentiasa benar*?” atau “Adakah ia *kadang-kadang benar*?” Jika anda fikir cara layanan anda itu hampir sentiasa benar, tandakan X pada kotak HAMPIR SENTIASA BENAR; jika kenyataan itu merupakan cara layanan anda yang kadang-kadang anda lakukan, tandakan KADANG-KADANG BENAR. Jika anda rasakan cara anda melayan anak itu pada asasnya tidak benar, tanya diri anda, “Adakah ia *jarang-jarang benar*?” atau “Adakah ia *tidak pernah benar*?”. Jika ia merupakan cara layanan terhadap anak anda yang jarang-jarang benar anda lakukan tandakan X dalam kotak JARANG-JARANG BENAR; jika anda rasakan kenyataan itu merupakan cara layanan anak anda yang tidak pernah benar tandakan kotak HAMPIR TAK PERNAH BENAR.

Ingat, tidak terdapat jawapan yang betul atau salah untuk mana-mana kenyataan. Oleh itu lakukanlah dengan benar dan tulus . Berikan maklumbalas yang anda benar-benar rasakan cara anda melayan anak anda dan tidak cara anda ingin melayan mereka. Sebagai contoh, jika anda hampir sentiasa memeluk dan mencium anak anda apabila ia berkelakuan baik, anda harus menandakan kenyataan itu seperti berikut.

	BENAR BAGI SAYA		TIDAK BENAR BAGI SAYA	
	<i>Hampir Sentiasa Benar</i>	<i>Kadang-kadang Benar</i>	<i>Jarang-jarang benar</i>	<i>Hampir Tak Pernah Benar</i>
Saya memeluk dan mencium anak saya apabila ia berkelakuan baik	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		BENAR BAGI SAYA		TIDAK BENAR BAGI SAYA	
		<i>Hampir Sentiasa Benar</i>	<i>Kadang-kadang Benar</i>	<i>Jarang-jarang benar</i>	<i>Hampir Sentiasa Benar</i>
1.	Saya cakap perkara baik mengenai anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Saya tidak memberi perhatian kepada anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Saya jadikan mudah untuk anak saya mencurahkan hatinya kepada saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Saya pukul anak saya walaupun dia mungkin tidak patut dipukul	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Saya lihat anak saya sebagai pengacau besar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Saya menghukum anak saya apabila saya marah	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Saya terlalu sibuk untuk menjawab soalan anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Saya tidak dapat menerima anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Saya benar-benar berminat dalam apa yang dilakukan anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	Saya katakan banyak perkara yang tidak baik dan menyakitkan kepada anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.	Saya tidak memberi perhatian kepada anak saya apabila dia meminta pertolongan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.	Saya buat anak saya rasa diingini dan diperlukan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.	Saya memberi perhatian yang banyak kepada anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.	Saya melukai perasaan anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.	Saya lupa perkara-perkara penting yang anak saya rasa saya perlu ingat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.	Saya buat anak saya rasa tidak disayangi jika dia berkelakuan tidak baik	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.	Saya buat anak saya merasakan apa yang dibuatnya penting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.	Apabila anak saya melakukan sesuatu kesalahan, saya takutkan atau ugut dia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.	Saya mengambil berat apa yang difikirkan oleh anak saya dan saya galakkan dia bercakap tentangnya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Saya rasa anak orang lain lebih baik dari anak saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.	Saya biarkan anak saya tahu yang dia tidak diingini	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.	Saya biarkan anak saya tahu yang saya menyayanginya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.	Saya tidak memberi perhatian kepada anak saya selagi dia tidak melakukan sesuatu yang mengganggu saya	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.	Saya melayan anak saya dengan lembut dan baik hati.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social Science Ethics Officer  
Private Bag 01 Hobart  
Tasmania 7001 Australia  
Tel (03) 6226 2764  
Fax. (03) 6226 7148  
Marilyn Knott@utas.edu.au



## MEMORANDUM

HUMAN RESEARCH ETHICS COMMITTEE (TASMANIA) NETWORK

### **FULL ETHICS APPLICATION APPROVAL**

07 July 2010

Professor Rapson Gomez  
Psychology  
Private Bag 30  
Hobart

**Ethics Reference: H11227**

**Childhood Psychopathology in Malaysia and its relationship with parental belief**

**Student: Aida Hj Suhaimi**

Dear Professor Gomez

The Tasmania Social Sciences HREC Ethics Committee approved the above project on 07 July 2010

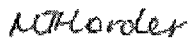
Please note that this approval is for four years and is conditional upon receipt of an annual Progress Report. Ethics approval for this project will lapse if a Progress Report is not submitted.

The following conditions apply to this approval. Failure to abide by these conditions may result in suspension or discontinuation of approval

- 1 It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval, to ensure the project is conducted as approved by the Ethics Committee, and to notify the Committee if any investigators are added to, or cease involvement with, the project
2. Complaints If any complaints are received or ethical issues arise during the course of the project, investigators should advise the Executive Officer of the Ethics Committee on 03 6226 7479 or [human\\_ethics@utas.edu.au](mailto:human_ethics@utas.edu.au)
3. Incidents or adverse effects Investigators should notify the Ethics Committee immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.

4. Amendments to Project: Modifications to the project must not proceed until approval is obtained from the Ethics Committee. Please submit an Amendment Form (available on our website) to notify the Ethics Committee of the proposed modifications.
5. Annual Report: Continued approval for this project is dependent on the submission of a Progress Report by the anniversary date of your approval. You will be sent a courtesy reminder closer to this date. **Failure to submit a Progress Report will mean that ethics approval for this project will lapse.**
6. Final Report: A Final Report and a copy of any published material arising from the project, either in full or abstract, must be provided at the end of the project.

Yours sincerely



Melanie Horder  
Ethics Officer



## APPENDIX C

UNIT PERANCANG EKC  
Economic Planning Unit  
JABATAN PERDANA MENTERI  
Prime Minister's Department  
BLOK B5 & B6  
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN  
62502 PUTRAJAYA  
MALAYSIA



**EPU**  
ECONOMIC PLANNING UNIT  
PRIME MINISTER'S DEPARTMENT

Telefon : 603-8888 3333

Ruj. Tuan:

Your Ref.:

UPE: 40/200/19/2600

Ruj. Kami:

Our Ref.:

Tarikh:

Date:

5 April 2010

Aida Farhana Hj Suhaimi  
244a, Macquarie Street  
Hobart, Tasmania  
**Australia.**  
Email: aida.hjsuhaimi@gmail.com

### APPLICATION TO CONDUCT RESEARCH IN MALAYSIA

With reference to your application, I am pleased to inform you that your application to conduct research in Malaysia has been *approved* by the **Research Promotion and Co-Ordination Committee, Economic Planning Unit, Prime Minister's Department**. The details of the approval are as follows:

Researcher's name : **AIDA FARHANA BINTI HJ SUHAIMI**

Passport No. / I. C No: **870111-56-5098**

Nationality : **MALAYSIAN**

Title of Research : **"CHILDHOOD PSYCHOPATHOLGY IN MALAYSIA  
AND ITS ASSOCIATION WITH PARENTAL  
BELIEFS"**

Period of Research Approved: **18 MONTHS**

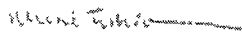
2. Please collect your Research Pass in person from the Economic Planning Unit, Prime Minister's Department, Parcel B, Level 1 Block B5, Federal Government Administrative Centre, 62502 Putrajaya and bring along two (2) passport size photographs. You are also required to comply with the rules and regulations stipulated from time to time by the agencies with which you have dealings in the conduct of your research.

3. I would like to draw your attention to the undertaking signed by you that you will submit without cost to the Economic Planning Unit the following documents:

- a) A brief summary of your research findings on completion of your research and before you leave Malaysia; and
- b) Three (3) copies of your final dissertation/publication.

4. Lastly, please submit a copy of your preliminary and final report directly to the State Government where you carried out your research. Thank you.

Yours sincerely,



(MUNIRAH ABD. MANAN)

For Director General,

Economic Planning Unit.

E-mail: [munirah@epu.gov.my](mailto:munirah@epu.gov.my)

Tel: 88725281

Fax: 88883961

ATTENTION

This letter is only to inform you the status of your application and **cannot be used as a research pass.**

## APPENDIX D



JABATAN PELAJARAN WILAYAH PERSEKUTUAN KUALA LUMPUR  
PERSIARAN DUTA, OFF JALAN DUTA  
50604 KUALA LUMPUR.  
Tel : 03-6203 7777 Faks : 03-62037788  
Laman Web : <http://www.moe.gov.my/jpwpl>



Rujukan Kami : JPWP 12-21/Jld.8-10/(160)  
Tarikh : 9 JUN 2010

Aida Farhana Hj Suhaimi  
Impian Den Sg Serai Batu 11,  
Jalan Hulu Langat  
43100 Hulu Langat Selangor

Y. Bhg. Dato/Datin/Tuan/Puan,

**KEBENARAN UNTUK MENJALANKAN KAJIAN DI SEKOLAH-SEKOLAH, MAKTAB-MAKTAB PERGURUAN, JABATAN-JABATAN PELAJARAN DAN BAHAGIAN-BAHAGIAN DI BAWAH KEMENTERIAN PELAJARAN MALAYSIA**

Dengan hormatnya saya diarah memaklumkan bahawa permohonan Y. Bhg. Dato/Datin/Tuan/Puan untuk menjalankan kajian bertajuk :-

**" Childhood Psychopathology And Its Relationship With Parental Behaviour "**  
adalah diluluskan tertakluk kepada syarat-syarat berikut:-

- Kelulusan ini adalah berdasarkan kepada apa yang terkandung di dalam cadangan penyelidikan yang telah diluluskan oleh Kementerian Pendidikan Malaysia.ila kemukakan surat kebenaran ini ketika berurusan dengan Pengetua/Guru Besar sekolah berkenaan.
- Kelulusan ini untuk sekolah-sekolah di Wilayah Persekutuan Kuala Lumpur sahaja
- Y. Bhg. Dato/Datin/Tuan/Puan dikehendaki mengemukakan senaskah hasil kajian tuan/puan ke Jabatan ini sebaik sahaja ianya siap sepenuhnya.
- Kebenaran ini sah sehingga 31.12.2010

Sekian, terima kasih.

**"BERKHIDMAT UNTUK NEGARA"**

Saya yang menurut perintah,

*A. Siti Halimah* 9/6

( SITI HALIMAH BT SYED NORDIN )  
Penolong Pendaftar Institusi Pendidikan  
Jabatan Pelajaran Wilayah Persekutuan  
b p Ketua Pendaftar Institusi Pendidikan & Guru  
Kementerian Pelajaran Malaysia



CERTIFIED TO ISO 9001:2000, CERT NO : AR 4166

**"CEMERLANG DALAM KALANGAN YANG CEMERLANG"**

(Sila catatkan no. rujukan Jabatan ini apabila berurusan)



## APPENDIX E



جاینت قلا جارت ساروقور  
**JABATAN PELAJARAN NEGERI SELANGOR**  
Jalan Jambu Bol 4/3E, Seksyen 4, 40604 Shah Alam  
Tel : 03-5518 6208 Faks : 03-55129704 E-mail jpnssel@sel.moe.gov.my  
Website: http://www.moe.gov.my/jpnssel



Rujukan Tuan :  
Rujukan Kami : JPNS/SPS/PPN/A25090/06/25/JLD 61/ ( 56 )  
Tarikh : 15/06/2010

AIDA FARHANA HJ. SUHAIMI,  
IMPIAN DEN SG. SERAI, BATU 11,  
JALAN HULU LANGAT,  
43100 HULU LANGAT,  
SELANGOR DARUL EHSAN.

Tuan,

### CHILDHOOD PSYCHOPATHOLOGY IN MALAYSIA AND ITS ASSOCIATION WITH PARENTAL BELIEFS

Dengan segala hormatnya perkara di atas dirujuk.

2. Jabatan ini tiada halangan untuk pihak tuan menjalankan kajian / penyelidikan tersebut di sekolah-sekolah dalam Negeri Selangor seperti yang dinyatakan dalam surat permohonan.

3. Pihak tuan diingatkan agar mendapat persetujuan daripada Pengetua / Guru Besar supaya beliau dapat bekerjasama dan seterusnya memastikan bahawa penyelidikan dijalankan hanya bertujuan seperti yang dipohon. Kajian / Penyelidikan yang dijalankan juga tidak mengganggu perjalanan sekolah serta tiada sebarang unsur paksaan.

4. Tuan juga diminta menghantar senaskah hasil kajian ke Unit Perhubungan & Pendaftaran Jabatan Pelajaran Selangor sebaik selesai penyelidikan / kajian.

Sekian, terima kasih.

"BERKHIDMAT UNTUK NEGARA"

"KEJUJURAN DAN KETEKUNAN"

Saya yang menurut perintah,

( MOHD SALLEH BIN MOHD KASSIM )  
Penolong Pendaftar Institusi Pendidikan,  
b.p. Pendaftar Institusi Pendidikan Dan Guru,  
Jabatan Pelajaran Selangor.

s.k. 1. Fall



(Silu catitkan nombor rujukan apabila berurusan dengan kami)

**JABATAN PELAJARAN NEGERI SELANGOR**  
PERRILANG

No. Telefon:  
03 - 5518 6208  
No. Faksimili:  
03 - 55129704  
Email:  
jpnssel@sel.moe.gov.my  
jpnssel@sel.moe.gov.my  
Laman Web:  
www.moe.gov.my/jpnssel

## APPENDIX F (1)

Aida Farhana Hj Suhaimi

School of Psychology

University of Tasmania, Hobart,

7001, Tasmania,

Australia

Date

Dear School Principal,

My name is Aida Hj Suhaimi and I am undertaking a Masters in Psychology (Clinical) Degree at the University of Tasmania, Australia. As part of this degree programme I am conducting a research under the supervision of Professor Rapson Gomez. This research study investigates the incidence level of childhood behavioural problems in Malaysian primary school children and its relationship with parental behaviours.

Permission to conduct the study has been obtained from the Tasmanian Social Sciences Human Research Ethics Committee and the Research Promotion and Co-Ordination Committee of the Prime Minister's Department, Malaysia (see attachments).

I would like to invite your school to participate in this research. This research will be survey based on mother's report and attached is a Plain Language Statement providing more details on the research study that will be conducted.

I would like to conduct the study in the next two weeks. I will call your school in advance to discuss your interest in the study during this time. Please do not hesitate to contact me should you have any questions prior to the call. I can be contacted via email, [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com) . Your co-operation is very much appreciated.

Sincerely,

-----

Aida Farhana Hj Suhaimi

Masters of Psychology (Clinical)

University of Tasmania

## APPENDIX F.(2)

Aida Farhana Hj Suhaimi  
Fakulti Psikologi  
University of Tasmania, Hobart,  
7001, Tasmania  
Australia

Tarikh

Tuan/Puan,

### **Subjek: Kebenaran Menjalankan Kajian Thesis Ijazah Sarjana**

Saya, Aida Farhana Hj Suhaimi, seorang pelajar dalam jurusan Ijazah Sarjana Psikologi Klinikal di University of Tasmania, Australia. Sebagai sebahagian daripada program ijazah sarjana saya, saya akan mengendalikan sebuah projek kaji selidik di bawah penyeliaan Professor Rapson Gomez. Projek ini akan menyiasat masalah perlakuan di kalangan kanak-kanak sekolah rendah di Malaysia dan hubungannya dengan perlakuan ibu bapa.

Surat kebenaran telah diperolehi daripada Tasmanian Social Sciences Human Research Ethics Committee dan Unit Perancangan Ekonomi, Jabatan Perdana Menteri, Malaysia (surat- surat disertakan).

Saya ingin mengundang sekolah anda untuk mengambil bahagian dalam kajian ini. Kajian ini melibatkan soal kaji selidik (survey) yang akan diisi oleh para ibu. Surat kenyataan bahasa harian disertakan bersama surat ini dan mengandungi semua perkara dan maklumat terperinci mengenai kajian yang akan dijalankan.

Saya berhasrat untuk menjalankan kajian ini dan mengumpul data dalam masa dua minggu yang akan datang. Saya akan menghubungi sekolah Tuan/Puan untuk mengetahui keinginan Tuan/Puan untuk mengambil bahagian dalam kajian ini. Jika anda memerlukan maklumat tambahan mengenai projek ini, sila hubungi saya melalui emel [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com). Kerjasama yang Tuan/Puan berikan amat dihargai.

Yang Ikhlas,

-----  
Aida Farhana Hj Suhaimi  
Mahasiswa Sarjana Psikologi Klinikal  
University of Tasmania

## **APPENDIX G (1)**

### **UNIVERSITY OF TASMANIA, AUSTRALIA**

#### **PLAIN STATEMENT FOR PRINCIPALS**

**PROJECT TITLE:** Childhood psychopathology in Malaysian children and its relationship with parental behaviour

#### **INVESTIGATORS:**

Student researcher: Aida Farhana Hj Suhaimi, Masters of Psychology (Clinical) Degree student

Chief Researcher : Professor Rapson Gomez, Professor in Clinical Psychology, School of Psychology, University of Tasmania, Australia

#### **AIMS OF STUDY**

This study has two major aims:

- (1) to provide an estimate of the level of childhood behaviour problems in Malaysian children, and
- (2) examine the relationship between the parenting styles and childhood behaviour problems in this group of children.

#### **PROCEDURE**

This project involves recruiting parents/guardians of primary school students, and to have them complete several questionnaires. The method of recruitment of children whose parents will complete the questionnaire for the study will be dependent on the wishes of individual school principals. For example, the principal and teachers could decide which classes and which children within these classes could be invited to participate in the study. Class teachers could then be in charge of distributing research materials to selected students.

Children who are selected will be given an envelope for their mothers. The envelope will contain a plain language statement (PLS) of the research and a questionnaire. Teachers will be requested to instruct these children to give the envelopes to their mothers.

Mothers' participation in this study involves completing a series of questionnaires. The questionnaire asks them about the town/suburb of residence, regular employment and ethnic background of the participant's child. This questionnaire then asks them about their child's behaviour and their parenting behaviour. Together these questionnaires will take 15 minutes to complete. Upon completion, mothers will be asked to seal them in a single larger

envelope to be passed to their children and given to their class teachers and I will then collect them from your school.

As this research is anonymous, participants will not be required to reveal their names. Participation in this research is entirely voluntary. Participants' consent to participate is implied by their completion and return of the questionnaire. Participants may choose to withdraw from the study at any time without prejudice, even while they are completing the questionnaires (however please note withdrawal after data collection will not be possible as we will be unable to distinguish individual responses).

Completed questionnaires will be kept entirely confidential and stored in locked cabinets or on password secured computers at the School of Psychology at the University of Tasmania. Data will be kept for a period of at least five years from the date of publication and then securely destroyed. No participant will be personally identifiable in any published research.

Whilst no specific risks are anticipated from participating in this study, it is possible that participants may experience some discomfort in answering some questions. In the event that participants experience any distress we provide contact details of support services or organisations such as The Befrienders Kuala Lumpur 24-hour helpline (03-79568144 or 0379568145) or Malaysian Mental Health Association (MMHA) (03-7782 5499).

We will cover all costs and materials for the study. If you wish to know more about the study, you can contact me via email [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com).

I hope to hear from you soon and I hope your school will be able to participate in this research project.

---

Aida Hj Suhaimi  
Masters of Psychology (Clinical) Degree student  
University of Tasmania

## APPENDIX G (2)

UNIVERSITY OF TASMANIA, AUSTRALIA

### KENYATAAN BAHASA HARIAN UNTUK PENGETUA SEKOLAH

**Tajuk Kajian:** Psikopatologi kanak-kanak di Malaysia dan hubungannya dengan tingkah laku ibu bapa

**Penyelidik:**

Penyelidik mahasiswa: Aida Farhana Hj Suhaimi, Mahasiswa Ijazah Sarjana Psikologi Klinikal  
Ketua Penyelidik: Professor Rapson Gomez, Professor Psikologi Klinikal, Fakulti Psikologi,  
University of Tasmania, Australia

**Tujuan Kajian:**

Kajian ini mempunyai dua tujuan utama:

- (1) menyediakan maklumat mengenai tahap masalah tingkah laku di kalangan kanak-kanak sekolah rendah di Malaysia
- (2) dan mengkaji hubungan antara perlakuan ibu bapa dengan anak-anak mereka dan masalah tingkah laku anak-anak ini

**Prosedur**

Kami berharap untuk melibatkan ibu bapa/ penjaga kanak-kanak sekolah rendah melalui sekolah anda untuk kajian ini.

Projek ini melibatkan ibu bapa/ penjaga pelajar sekolah rendah melengkapkan beberapa kertas soal jawab. Cara proses ini dilakukan bergantung kepada hasrat individu pengetua sekolah. Contohnya, pengetua atau cikgu boleh memilih dan menganal pasti kelas dan pelajar yang akan mengambil bahagian dalam kajian ini. Setelah kelas dan pelajar dikenalpasti, guru kelas kemudiannya boleh mengedarkan kertas-kertas soalan kajian ini kepada pelajar-pelajar terlibat.

Kanak-kanak yang terpilih akan diberi sampul surat untuk diserahkan kepada ibu bapa/penjaga mereka. Sampul surat ini mengandungi kenyataan bahasa harian projek ini dan set soalan. Guru kelas akan diminta untuk mengarahkan kanak-kanak ini untuk memberi sampul surat ini kepada ibu bapa/penjaga mereka.

Kertas soal-selidik ini melibatkan ibu bapa/penjaga menjawab beberapa kertas soal-selidik. Kertas soal selidik ini bermula dengan soalan berkenaan kawasan tempat tinggal, pekerjaan mereka dan latar belakang etnik pelajar. Kertas soal selidik ini kemudiannya akan bertanya tentang tingkah laku kanak-kanak ini dan perlakuan ibu bapa/ penjaga dengan kanak-kanak.

Kertas soal selidik ini akan mengambil masa lebih kurang 15 minit untuk diisi oleh ibu/bapa/penjaga bagi setiap pelajar. Apabila kertas-kertas soalan ini telah dilengkapkan, mereka akan diminta menyerahkan sampul surat berisi kertas-kertas soalan ini kepada guru kelas dan saya akan datang untuk memungutnya dari sekolah anda.

Peserta dalam kajiselidik ini tidak perlu memberi nama atau mengenalkan diri. Penyertaan adalah secara sukarela. Menjawab senarai soalan kajiselidik di anggap sebagai persetujuan untuk mengambil bahagian dalam kajiselidik ini. Peserta boleh mengundur diri pada bila - bila masa tanpa apa-apa halangan. Bagaimanapun pengunduran diri selepas pengumpulan data tidak mungkin kerana pihak kami tidak akan dapat mengenalpasti respon peserta.

Segala kos kajian ini akan dibiaya oleh pihak kami. Sekiranya anda ingin mengetahui dengan lebih lanjut tentang kajian ini, sila hubungi saya melalui emel [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com).

Saya berharap sekolah anda sudi bekerjasama dengan saya dalam projek ini. Saya akan menantikan maklum balas anda.

-----  
Aida Hj Suhaimi  
Mahasiswa penyelidik (program Sarjana Psikologi Klinikal),  
University of Tasmania

## APPENDIX H (1)

### UNIVERSITY OF TASMANIA, AUSTRALIA PLAIN STATEMENT FOR PARENTS/GUARDIANS

**PROJECT TITLE:** Childhood psychopathology in Malaysian children and its relationship with parental behaviour  
**INVESTIGATORS:**

**Student researcher:** Aida Farhana Hj Suhaimi, Masters of Psychology (Clinical) student

**Chief Researcher :** Professor Rapson Gomez, Professor in Clinical Psychology, School of Psychology, University of Tasmania, Australia

My name is Aida Farhana Hj Suhaimi and as part of my Masters of Psychology studies at the University of Tasmania I am undertaking a research project under the supervision of Prof. Rapson Gomez. In this project I am investigating the incidence of childhood behavioural problems in Malaysian primary school children and its relationship with parental behaviours. I would like to invite you to participate in this project.

Participation in this study involves completing a series of questionnaires. We would like these questionnaires to be completed by the mother. However, if this is not possible, the father or a guardian can complete them. The questionnaires that you are expected to complete are attached. The questionnaire begins by asking you about your town/suburb of residence, regular employment and child's ethnic background. This questionnaire then asks about your child's behaviour over the last month and whether 25 statements about your child is not true, somewhat true or certainly true. For example, you will be asked whether your child is restless, overactive, cannot stay still for long. Following this, is another set of questionnaire that asks about parental behaviour. For example, "I say nice things about my child" and whether the statement is true or not true of you. In all, these questionnaires will take you about 15 minutes to complete. Upon completion, you will be asked to seal the completed questionnaires in a single larger envelope to be passed to your child and given to their class teachers.

As this research is anonymous, you will not be required to reveal your name. Participation in this research is entirely voluntary. Your consent to participate is implied by your completion of the questionnaire. You may choose to withdraw from the study at any time without prejudice, however please note withdrawal after data collection will not be possible as we will be unable to distinguish your responses from other participants.

Completed questionnaires will be kept entirely confidential and stored in locked cabinets or on password secured computers at the School of Psychology at the University of Tasmania. Data will be kept for a period of at least five years from the date of publication and then securely destroyed. No participant will be personally identifiable in any published research.

Whilst no specific risks are anticipated from participating in this study, it is possible you may experience some discomfort in answering some questions. In the event that you experience any distress we encourage you to seek counselling from a provider of your choice, support services or organisations such as The Befrienders Kuala Lumpur 24-hour helpline (03-79568144 or 0379568145) or Malaysian Mental Health Association (MMHA) (03-7782 5499). If you wish to know more about the study, you can contact me via email [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com).

This study will be completed by October 2010, with further results expected by October 2011. This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee and Research Promotion and Co-Ordination Committee of the Prime Minister's Department, Malaysia.

Thank you for considering participating in this research. It is truly appreciated.

Aida Hj Suhaimi

Research Student (Masters of Psychology (Clinical)), University of Tasmania



## APPENDIX H (2)

### **UNIVERSITY OF TASMANIA, AUSTRALIA** **KENYATAAN BAHASA HARIAN UNTUK IBU BAPA/PENJAGA**

**Tajuk Kajian:** Psikopatologi kanak-kanak di Malaysia dan hubungannya dengan tingkah laku ibu bapa

**Penyelidik:**

**Penyelidik mahasiswa:** Aida Farhana Hj Suhaimi, Mahasiswa Ijazah Sarjana Psikologi Klinikal

**Ketua Penyelidik:** Professor Rapson Gomez, Professor Psikologi Klinikal, Fakulti Psikologi, University of Tasmania, Australia

Nama saya Aida FarhanaSuhaimi dan sebagai sebahagian daripada ijazah Sarjana Psikologi Klinikal saya di University of Tasmania saya akan mengendalikan sebuah projek kaji selidik di bawah penyeliaan Prof. Rapson Gomez. Di dalam projek ini saya akan menyiasat masalah perlakuan di kalangan kanak-kanak sekolah rendah di Malaysia dan hubungannya dengan perlakuan ibu bapa. Saya ingin mengundang anda untuk mengambil bahagian dalam projek ini

Anda perlu melengkapkan satu set kertas soal selidik. Saya amat berharap agar para ibu dapat melengkapkan kertas soal selidik ini. Walaubagaimanapun, jika ini tidak dapat dilakukan, para bapa atau penjaga boleh melengkapkan kertas soal selidik ini yang akan disertakan bersama surat kenyataan ini. Anda akan ditanya berkenaan kawasan tempat tinggal, pekerjaan anda dan latar belakang etnik anak anda. Kertas soal selidik ini kemudiannya akan bertanya tentang langkah laku anak anda. Contohnya, anda akan ditanya samada anak anda gelisah, terlalu aktif dan tidak dapat diam untuk masa yang panjang. Seterusnya, anda akan ditanya mengenai perlakuan ibu bapa. Contohnya, "Saya cakap perkara baik mengenai anak saya". Anda harus jawab samada kenyataan itu benar ataupun tidak tentang anda. Jangka masa untuk menjawab semua kertas soal selidik ini adalah lebih kurang 15 minit. Setelah tamat di isi, sila masukkan kertas soal selidik ini dalam sampul surat yang diberi dan serahkan kepada anak anda untuk diserahkan kepada guru kelasnya.

Peserta dalam kajiselidik ini tidak perlu memberi nama atau mengenalkan diri. Penyertaan adalah secara sukarela. Menjawab senarai soalan kajiselidik di anggap sebagai persetujuan untuk mengambil bahagian dalam kajiselidik ini. Peserta boleh mengundur diri pada bila-bila masa tanpa apa-apa halangan. Bagaimanapun pengunduran diri selepas pengumpulan data tidak mungkin kerana pihak kami tidak akan dapat mengenalpasti respon peserta.

Soalan kajian selidik yang telah lengkap adalah rahsia dan akan disimpan di dalam kabinet berkunci atau komputer bersekuriti di Fakulti Psikology, University of Tasmania, Australia. Data yang dikumpul akan disimpan selama lima tahun dari masa kajian diterbitkan dan akan dihapuskan. Tiada peserta akan dapat dikenali dalam mana-mana terbitan.

Soalan-soalan yang ditanya tidak secara amnya menimbulkan kegelisahan. Walaubagaimanapun, sekiranya timbul rasa kurang senang sepanjang melengkapkan soalan yang diberi anda dinasihatkan untuk menghubungi servis bantuan atau organisasi yang boleh menyediakan pertolongan seperti Befrienders Kuala Lumpur talian pertolongan 24-jam (03-79568144 or 0379568145) atau Malaysian Mental Health Association (MMHA) (03-7782 5499). Jika anda ingin tahu lebih lanjut mengenai kajian ini, sila hubungi saya secara emel [aida.hjsuhaimi@gmail.com](mailto:aida.hjsuhaimi@gmail.com). Kajian ini telah memperoleh kebenaran daripada Tasmanian Social Sciences Human Research Ethics Committee dan Unit Perancangan Ekonomi, Jabatan Perdana Menteri, Malaysia. Saya berharap anda akan bersetuju mengambil bahagian dalam projek ini. Segala kerjasama amat dihargai.

Aida Farhana Hj Suhaimi

Mahasiswa penyelidik (program Sarjana Psikologi (Klinikal), University of Tasmania